PUBLIC HEALTH NURSING

APRIL
1946

The Advantages of Meat in Pregnancy and Lactation Again Affirmed

The need for an augmented protein intake during pregnancy and lactation has long been known. In a recent controlled study,* the value of increasing the protein consumption during the last four months of pregnancy and the first three months of lactation was again demonstrated. The subjects were instructed to "eat plenty of meat—a generous serving at least twice a day." The average protein intake was augmented by 5 ounces of meat supplied daily to each subject.

Careful observation disclosed that the women receiving the larger meat ration "had consistently better hemoglobin and red cell values at all times than did their experimental partners who received either B complex or no supplement." Furthermore, the group receiving the extra meat showed less edema, had better success at lactation, and felt better than they did during previous pregnancies.

Thus the value of meat as a source of protein in pregnancy and lactation is again affirmed. Containing all the essential amino acids, meat satisfies all protein needs.

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*Leverton, R. M., and McMillan, T. J.: Meat in the Diet of Pregnant Women, J.A.M.A. 130:134 (Jan. 19) 1946

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PUBLIC HEALTH NURSING

VOL. 38, NO. 4 APRIL 1946

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Editor: MARY EDWARDS SHAW *Editorial Consultant:* ALBERTA B. WILSON, R.N.
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PUBLIC HEALTH NURSING

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NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING, INC.

1790 Broadway, New York 19, N. Y.

The National Organization for Public Health Nursing is a membership organization composed of individual and agency members. Its purpose is to serve as a clearing house of information, and to develop and interpret standards for personnel and practices in public health nursing. This is accomplished through an advisory service to individuals and agencies interested in public health nursing; through publications, including the official magazine PUBLIC HEALTH NURSING; and through connections with national, state, and local agencies in related fields. The organization is administered by an elected board of lay and professional members and its activities are carried on by committees representing public health nursing and related fields, and by an employed staff.

The organization has no jurisdiction over its membership. It serves in a purely advisory capacity and the acceptance of any of its recommendations is entirely voluntary.

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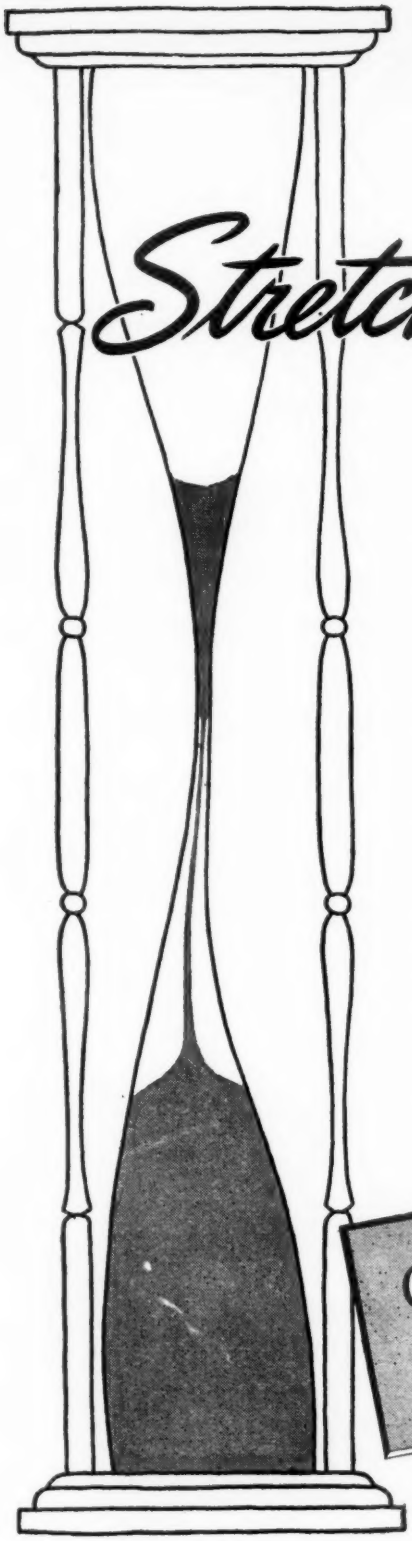

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PUBLIC HEALTH NURSING

Official Organ of the National Organization for Public Health Nursing, Inc.

Public Health Nurses and Legislative Action

BY FAR THE MOST numerous group of all the professional personnel in public health work, public health nurses stand to be relatively the most affected by the enactment into law of any one of a number of major public health proposals pending in Congress. Nor does their involvement end here as many of the states are pressing legislative action and coming state legislative sessions will debate and perhaps pass a variety of health measures. Public health nurses face possible change in a number of ways—in numbers, in types of employing agencies, in the services they will be asked to give and where they will be asked to give them, in opportunities afforded for further and specialized preparation, and in personal benefits offered.

Because public health nurses are asking for help in interpreting the manifold bills which are of such importance to them professionally and to their families and communities, the NOPHN Board of Directors in January 1946 voted the appointment of a special committee to study health legislation and keep the membership informed through PUBLIC HEALTH NURSING and other channels. The National Nursing Council also, at its January meeting, voted the establishment of a committee to review federal legislation which affects nursing. The American Public Health Association Subcommittee on Medical Care recently opened an office with technical staff in Washington to "review proposed federal and state health legislation in the light of declared principles and to recommend to the Association a stand with respect to such legislation." The American Nurses' Association has a special committee on federal legislation with representatives in Washington, and a part-time headquarters staff member in Washington whose work is in the interest of federal legislation. The ANA is also represented by a delegate to the Women's Joint Congressional Committee. From these committees as well as a number of other established sources valuable information and practical help should be forthcoming.

Dr. Nathan Sinai, president of the Michigan Public Health Association and NOPHN Board member, has this to say about our attitude toward health legislation:*

"When a proposal involves the health of the people, no public health worker will conclude without careful study that it should be supported or opposed. And on matters of health legislation no public health worker will take the easy refuge that is offered in the public polls, the refuge of 'undecided' or 'no opinion.' For the public health worker to maintain a mental aloofness while these subjects are being debated may mean that he holds one of two or three viewpoints. First, he may remain aloof because the subjects are controversial. This is not a flattering reason that may be assigned to his seeming disinterest. Second, he may feel that public health is a distinct field and that the legislative subjects have only a remote relationship to public health work. . . . The public health worker who attempts to maintain a disinterest in the legislative proposals is in an untenable position. In its effect he is in the position of judging the efficacy of his work according to specified services and, at the same time, remaining aloof from influences that must affect greatly the very same services. This is no plea for support or opposition to any particular legislation or any proposal. It is a plea for some-

*Sinai, Nathan. "Proposed Health Legislation." *Michigan Public Health,* December 1945, p. 225.

thing much more fundamental—objective analysis and judgment. The legislative proposals are far-reaching; in the event of adoption of any one of them no health department and few health workers will remain unaffected."

More than a dozen major proposals are pending in Congress. Public hearings have been held on many of them. Several of these are listed below with a note as to their current status. Because of their detailed nature, however, no present attempt is made to quote from them. Summaries have been prepared by experts and are available from several authoritative sources. It will pay those readers who are interested, and we all should be, to seek further information. The magazine will keep readers in touch with further legislative action.

When as individuals and as agencies we have given these bills "objective analysis and judgment," what can we do?

The individual citizen can write his representative and senators that he supports or opposes a given bill and give his reasons. He can write, or visit them when they are at home, to get their views on the bill and to express his own opinions. He can also write the Congressional sponsors of the bill and the members of the particular committees of the Senate or House, who are planning and conducting public hearings. He or his agency can ask the privilege of presenting testimony at hearings or of submitting a statement. He can urge each of the organizations of which he is a member to discuss the bill at meetings and to pass resolutions expressing the organization's collective convictions. He can then propose sending the resolutions to senators and representatives with supporting data and explanations. He can always be sure that members of Congress, as well as state legislators and city council members, when state or local legislation is in question, will welcome communications from citizens who want to get information or to give expression to considered opinions. He can join with leaders in his community and with friends and neighbors to determine on a constructive course of action in voicing public opinion. He can write his local newspapers about his own stand on the bill and urge both newspapers and radio stations to carry informative articles and programs on the subject. He can register and exercise his voting privilege where he wishes it to count.

Organizations can assist their members by making needed analyses and studying the application of proposed measures. Tax-exempt agencies are not precluded from making such studies and publishing their findings or giving factual statements at public hearings. The laws provide, however, that they cannot spend a major part of their time and effort in activities of this character related to legislative matters, without danger of jeopardizing their tax-exempt status.

Here are some of the federal legislative proposals now under consideration in Congress:

National Mental Health Act—S1160 and HR4512 (This supplants the National Neuropsychiatric Act, HR2550)

House Committee on Interstate and Foreign Commerce reported favorably on HR4512 and the House passed the bill with minor amendments.

Senate Committee on Health and Education has completed hearings on S1160 and the bill as passed by the House. The Committee has referred the matter back to a subcommittee for clarification of details and a written report. It is not known when final action will be taken.

Hospital Survey and Construction Act—S191 (Hill-Burton Bill)

House Committee on Interstate and Foreign Commerce has concluded public hearings on the bill, will report action shortly.

Senate Committee on Education and Labor recommended an amended bill to the Senate which passed it December 11, 1945.

Dental Health—S190 and S1099

Public hearings were held in June 1945 before the Senate Committee on Education and Labor.

Bills to continue permanently the social protection program in the Office of Community Services, Federal Security Agency—S1779 and HR5234.

Hearings were held by the Senate Committee on Education and Labor and by the House Committee on the Judiciary in March. Both committees reported favorably, recommending passage of the bill in Senate and House respectively. (See article by Lieutenant Gould, page 173, this issue.)

Maternal and Child Welfare Act of 1945—S1318 and HR4059 (S1318 sponsored by Senators Pepper and Murray and nine other senators.)

No public hearings have been announced.

National Health Act—S1606 and HR4730
(Wagner-Murray-Dingell Bill)

Public hearings began April 2 before the Senate Committee on Education and Labor. Testimony relative to Title I, Part B of S1606, on maternal and child health, is expected to be heard toward the end of April.

Wagner-Murray-Dingell Bill—S1050 and HR3293

This earlier general health bill is similar in some provisions to S1606. It has been referred to the Senate Committee on Finance. No action has been taken.

National School Lunch Act—S962 and HR3370

The House has passed HR3370 and the Senate S962, which are two different versions of the School Lunch Bill. A joint conference committee will now try to reach agreement on a bill acceptable to both Houses of Congress.

Social Security Amendments

The House Ways and Means Committee appointed a staff of experts to make a report on "Issues in Social Security." This has been published and is available from Rep. Robert C. Doughton, House Office Building, Washington 25, D.C. The House Ways and Means Committee is now holding hearings on proposed amendments to the Social Security Act, including suggestions offered by their own experts, the Federal Security Agency staff, and social security provisions in S1606. Three aspects are being considered (1) old-age and survivors insurance (2) public assistance (3) unemployment compensation.

General Housing Bill—S1592
(Wagner-Ellender-Taft Bill)

Based on long public hearings held by the Senate Subcommittee on Housing and Urban Redevelopment.

It was favorably reported by the Senate Banking and Currency Committee on April 8. Now being debated on the floor of the Senate.

Not yet referred to the House.

This bill has been endorsed by some 35 veterans, welfare, religious, and women's national organizations and many local groups. It seeks to establish a national policy and program directed toward the assurance of healthy, livable housing for all Americans, including the minorities and families of low income, in rural and farming areas and in urban centers.

Minimum Wage and Child Labor—S1349

Senate Committee on Education and Labor has recommended action on the bill, which is an amendment to the Fair Labor Standards Act of 1938, especially as it relates to strengthening the child labor provisions of the act.

SOURCES OF INFORMATION ABOUT HEALTH AND WELFARE LEGISLATION

Copies of Senate or House bills can be secured from the Superintendent of the Documents Room, in either the U. S. Senate or House of Representatives, Washington 25, D.C., depending on the bill desired.

Many national professional, and citizen's organizations are studying and making recommendations in relation to specific legislative proposals. Their published materials are available on request.

The following periodicals regularly publish summaries and comments on legislation:

Social Legislation Bulletin

"This Bulletin reports impartially on proposed and pending federal legislation affecting children and youths, as well as their families and communities."

Child Welfare Information Service, Inc., 930 F Street, N.W., Washington 4, D.C. Annual subscriptions in accordance with each organization's ability to pay. Introductory 3-month offer at $2.50.

Public Health Economics. A Monthly Compilation of Events and Opinions. Published by Public Health Economics, School of Public Health, University of Michigan, Ann Arbor. $3 per year.

Journal of the American Medical Association

Each week the Medical Legislation Section carries summaries of federal and state bills. 5353 North Dearborn Street, Chicago 10, Ill. $8 per year.

"Design For Serving"

By RUTH W. HUBBARD, R.N.

IN THIS YEAR of 1946, we observe an anniversary, in fact, our 60th birthday. It is a middle-aged birthday, one which we hope finds us in the prime of life, strengthened by the experience of our youth, enriched with the wisdom born of that experience, stabilized by the confidence of a proven service, and charged afresh with the determination to achieve the dream of the founders.

In middle-age we often look backward to revive our dreams, but our steady gaze is forward to as yet unrealized goals, and we press onward toward these goals.

Sixty years measured in decades is not long, but it is long enough for many things to happen to a man or a society. It is long enough for work and play, laughter and anxiety, satisfaction and concern, new methods and fresh belief in established convictions, new friends and the passing of old ones, wider calls for service, and the exit of early needs.

Let us first look backward for a moment over the six decades to review the past so that we may wisely and fearlessly look forward to the future.

The year 1886 saw Mrs. William Furness Jenks organizing a group of women to found the Visiting Nurse Society of Philadelphia. A back room was secured for an office, and with one nurse, one hundred dollars for capital, a fifty cent second-hand table for a desk, a blank copy-book for records, and a bale of oakum for the making of surgical dressings, these women went forth hopefully in quest of patients.

During the first few years its policies were definitely evolved and set forth, policies by which, with only a few important changes, the Society today gives efficient service to a greatly altered world. It was a far-reaching vision possessed by these women of over a half-century ago. First, there were the sick poor to be visited and nursed in their homes; second, "the furnishing of visiting nurses to those able to pay for necessary care, but who can hardly afford to keep a trained nurse in the house"; third, maternity nursing; fourth, the care of cases of infectious disease, by a nurse specially

Miss Hubbard is general director of the Visiting Nurse Society of Philadelphia.

employed; and fifth, supplying nurses "for daily visits to persons living in boarding houses or otherwise limited accommodations, and needing care"—a service which later developed into the Hourly Nursing Service. One significant policy that was shortly adopted was the employment of only hospital-trained nurses in all the work of the Society, a policy which has been consistently carried out to the present time.

The second decade was a period of steady growth and rapid discovery of need. Medical science at the turn of the century gave us our first gleam of hope in the prevention of communicable diseases. At last mankind could accept the protection of health as a valid concept and preventive medicine was born.

In the third decade we spread our efforts far afield in new services and new territories. The idea of a Visiting Nurse Society took hold of Southeastern Pennsylvania and neighborhoods and communities seeking their own nurses looked to Mrs. Lea, then president, her board and staff for leadership and help. The Metropolitan Life Insurance Company began its health program for industrial insurance policyholders and the use of public health nurses in schools and clinics was explored.

It was natural that the fourth and fifth decades should call for structural organization and expansion in personnel. The young agency began to take stock of itself, to lay a clearer plan for performance on an ever widening scale, and to take its place in community planning and development in health. The country now had its own National Organization for Public Health Nursing, and the story of the Visiting Nurse Society is closely allied with that of the "National."

New services were added—occupational therapy, an important factor in recovery; the use by our health officer of visiting nurses for the care of patients with communicable disease in their homes continued to the present. In this period we lived through the great influenza epidemic and the first World War—times so like the present in many of their aspects.

During these years our Community Fund was formed, and on Mrs. Jenks' own motion "for the greatest good to the greatest number" the Visiting Nurse Society became an original member.

This period saw, too, the formal development of our educational program although sound nursing education and professional preparation for the Society's work had been our lifelong concern. As early as 1892 students had come to the Society, and the stream of undergraduates and graduates has been unbroken. The Philadelphia General Hospital School holds the record for the oldest continuous affiliation and we are justly proud of this close association.

The records of our fifth decade show our largest staff and our greatest number of patients and visits.

In the closing years of the fifth decade, we, like all the world, suffered the economic depression, and the unfaltering courage of the supervisors and staff who carried our patients through that most paralyzing experience is a brilliant and heartening star in our memory.

So we come to the sixth decade and its completion tonight. The Social Security Act and the urgently needed expansion of official health services opened the period. World War II closed it. The Society no longer labored alone. Instead it was one of an ever increasing group of community workers actively concerned with health and welfare. In sixty short years we have changed from the status of lone rangers to members of an essential unit in a vast, well organized army. The establishment in our Council of Social Agencies of an active health division signified our community support of group endeavor.

The health of our citizens throughout life is our concern, and as a voluntary agency we continue to apply the principles of experimental work, the relinquishment of all proven service properly located elsewhere, while we strive to avoid alike duplication and uncovered needs.

The addition of the nutrition and orthopedic services, the development of nursing service in small industrial plants, the transfer of our well baby conferences to the Division of Child Hygiene, our close cooperation with the Venereal Disease Division, and our active participation in Philadelphia's generalized public health nursing service now under the experimental direction of Starr Centre illustrate our faith in these principles.

This, then, is the record. For sixty years we have given to Philadelphia nursing and health service for families built on the finest professional preparation possible and rendered with true understanding of each individual patient's

need. To us these are fundamental values of our existence as a voluntary agency.

The future lies before us and none of us can see accurately the way ahead. But there is a message I believe the Society wishes to give us as we embark on our next decade. It gives to each of us, Board, staff, patients, and community, a talisman for the journey.

Surrounded as we are with the multitude of details that encompass daily living in 1946, we may find it hard to stop, even for a moment, to listen to the words. Yet I am reminded by history that the times in which we live hold the same problems which other generations have had to meet. We are so close to them that we cannot easily attain perspective. A man who lived to be old in years, but remained young in heart, Justice Oliver Wendell Holmes, has said superbly what I believe the Society wishes to say to those of us on the Board and staff. If we can keep these words ringing in our ears and living in our hearts we shall surely realize—one day—the goal of our founders, "Have faith and pursue the unknown end"—"Want something fiercely and want it all the time." To each of us these words bring a special challenge.

In the service of the Society I have come to realize as never before the special privilege of being a nurse. To have a professional skill which is needed and wanted by others and to be aided in my effort to use that skill helpfully, through the constant assistance of the nonprofessional members of my group—this has become for me a treasure of high price. And I know as we all do that treasures cannot be hidden away. They must be used. The Society gives us the opportunity to keep our treasures by using them. Here in our corner of the world, amid anxiety, doubt, and confusion, we can go on with faith, fiercely wanting health for our families and our city, and working for it all the time.

To our patients, you whose doors have stood wide to us these sixty years, the message comes in words which are very old, simple, and direct. May you always find them true. Your public health nurse "openeth her mouth with wisdom and in her tongue is the law of kindness."

The Community of Philadelphia, which during our lifetime has grown into a community organized for the health and welfare of its members, looks forward, too, with us. We begin as a community to realize our strength. We have not yet achieved its full benefit. As John Buchan has said, "There is a potentiality of strength but till the strength is made actual, it is no better than weakness." Together we can make our strength for health actual.

Pictured on page 152 are Mrs. Frederick S. Kirk and Philip C. Staples cutting the giant birthday cake at the Society's 60th Anniversary dinner. The cake was found to contain a miniature automobile presented to the nurses of the Society by an anonymous donor.

A Report from India

HELEN BENJAMIN, long-time NOPHN member, writes from India about a recent Golden Jubilee Graduate Nurses' Reunion. She says, "I am all for the public health program and here in India we are just starting, but I am tied up with the administration of a hospital and just can't reach out. I trust next term younger nurses can carry on here and allow me to do something along public health lines. Thank you for your letter which made me see that my contribution will help carry on the work there at home through contributing my membership in NOPHN." Excerpts from her report follow:

Our Jubilee began with a feast for all former staff and workers. Mr. B. Samuel from our Seminary gave the group a Kalakshapam (story in song) afterwards. About 200 of us gathered together under the moonlit sky and listened to the story of Simeon.

On Saturday morning at sunrise the staff and workers met on the terrace of the bungalow for a praise service. Miss Bullard led us in a beautiful time of prayer and thanksgiving. There then followed a tree planting ceremony, the symbol of growth and service to God, establishing the event for each future group of graduating nurses. . . .

In the afternoon the hospital was opened to guests and the nurses displayed appropriate exhibitions in each section of the hospital. Three cages of white rats, demonstrating the value of different types of food, attracted much notice, as well as pictures of former staff and students, buildings, old instruments, and charts portraying Nursing and Medical History, Prevention of Accidents, Antenatal Care, Care of the Baby, and Prevention of Typhoid Fever. How much the public learned from these efforts is not known, but the nurses learned a lot. . . .

Visiting Nurse Society and Cancer Patient

By DOROTHEA McKEE, R.N.

THE FIRST and probably the most important service a visiting nurse society can give to cancer patients is that of prevention through the teaching of sound health measures and encouraging the habit of routine physical examinations at periodic intervals.

The corollary of this service is necessarily the readiness and ability of the medical profession to offer such thorough physical examinations that the individuals are satisfied that their expenditure of time and money is worth while. During the war period when physicians have been so few and the few so overburdened with emergency work, when many men and women have carried several jobs or put in many overtime hours at work, we have not been too successful in this part of our program. However, with the return of physicians and the settling down to peacetime living it is one aspect of our service which needs and will receive greater emphasis by our nurses.

The second contribution is the early discovery of suggestive symptoms. The effectiveness of this service depends a great deal upon the alertness of the individual nurse as she goes about her daily duties and upon the respect for her professional judgment which she has been able to build up in the families she meets.

Let me use actual case material to illustrate. Late one afternoon as a nurse was passing through her district on her way home, she was hailed by Mrs. S. Mrs. S, it seemed, had accidentally discovered a small lump in her left breast and she wanted to know what the nurse thought she ought to do about it. The nurse advised an immediate call to her family physician. This was done and an appointment was secured for the following day. The nurse left with the promise to return the day after the patient's visit to her doctor to help in any way she could to carry through the physician's directions. When the nurse returned on the appointed day she was unable to get into the house. Tacked on the door was a request for the bread man to leave no more bread until further notice as the patient had gone unexpectedly to the hospital. Several weeks passed and again the nurse was halted as she passed Mrs. S's home and was told that the lump had been removed, that Mrs. S was so grateful for the nurse's advice, as the surgeon had said he got the lump out just in time.

The giving of skilled nursing care is a third major contribution—not only because of the comfort this service gives to the patient, but also because of the relief brought to the family through the sharing of this care and the knowledge that a professionally responsible person is standing by during the ordeal which may extend over a period of months. Furthermore, the nurse can carry through to the patient, with the minimum of discomfort, treatments which are too difficult for an untrained person to give.

It is unnecessary to discuss here the details of nursing care except to state that the range of service extends from a simple bed bath and the hypodermic administration of medication through the intricacies of douches, catheterizations, bladder irrigations, colostomy irrigations and dressings, extensive surgical dressings to nasal and gastrostomy feedings and the stretching of sphincter muscles.

ANOTHER contribution which the nurse makes, and that few realize is the strengthening of the relationship between patient, family, and the physician. Often neither the patient nor his family knows the exact nature of the patient's illness, so now they may begin to feel that the family physician, who has never failed on previous occasions, seems to be slipping—he doesn't visit as often

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as the family thinks he should or, in spite of his frequent visits, the patient is losing ground. Or the specialist, the "professor," as so many of our patients call him, has not produced the hoped for results and the family contemplates shopping around. This service calls forth all the diplomacy and strategy which the nurse possesses. Occasionally her efforts fail and the trek from doctor to doctor begins. More frequently she is able to help the family see that the illness was incipient in onset, will need a long period of treatment, and that *the family physician knows them best and is more interested in the patient's welfare than a stranger could be,* that his professional standing is good and his judgment sound. So the bond is strengthened and a most helpful relationship continues.

Just being herself, a professional person who requires no pretense, is another real help. I think of an extremely intelligent patient for whom we recently cared. He had not been told his diagnosis, but he could make a pretty good guess. Before family, physician, and friends he put up a good front but one day he said to our nurse: "I'm so glad when you come. You know and I know what's the matter with me and that it's the end. With you I don't need to pretend." So the nurse is the outlet for patient's, sometimes the family's, emotions—fears, frustrations, pains, and despairs, which are expressed in a wide variety of behavior—beratings, weeping, sullenness, refusal to follow directions, complete withdrawing. The patient knows no matter how he acts the quality of his nursing care will not change.

Sometimes with a few patients the doctor deems it wise to share his knowledge of their diagnosis. Many and varied are the ways a nurse can help in situations like this: Mrs. T had been under treatment for a long time, but in spite of the help of the experts her disease progressed so rapidly that it seemed unwise to continue to subject her to treatments. She was sent home to make whatever arrangements were necessary for her family while she had the strength to plan. Mrs. T, you see, was the mother of five children. Mrs. T soon learned that the nurse was her friend and would share her problems, so one day she said, "Nurse, I know I can't get well and I'd be glad to go, I've suffered so, if I could be sure about my children." Then she told of her husband, devoted and a good provider when sober, but frequently absent for days following pay day. There was no other relative except an irresponsible, elderly mother-in-law, unfit to care for the children. "How can I be sure my children will be cared for and brought up properly?" she asked. The nurse explained children's agencies and their functions. An appointment was made for a worker to visit the home and through her, placement was arranged in a foster home which would provide good care and training and keep the family together until the eldest child, a daughter, was old enough to make a home for her sisters and brothers with her father's help. There was bitter opposition from husband and his mother, but this determined, devoted, dying mother carried through her plan. The nurse stood by, while this mother, dry-eyed, sent her children away from her for the last time, and she helped dry the tears which fell when the children were out of sight. She shared the letters which came from the eldest daughter telling of the new home, the new mother, the new school, and new friends. Occasionally the nurse shared a tear over the homesickness of the little group. Finally this dreadful period ended and one mid-morning the nurse arrived to find a peaceful and resigned woman with a freshly opened letter in her hand. "I can go now" was the patient's greeting. "They're happy! They'll not miss me too much! I know they'll get along!" Then the nurse knew that her service to Mrs. T was nearing the end, for soon the slender thread which had held her here would break and she, too, would start forth on her journey to a new, and, the nurse hoped, better home.

IN PUBLIC HEALTH NURSING we speak of objectivity in our relationships with patients. It is through this ability to temper her professional skill and knowledge with sympathy and understanding that the nurse makes one of her greatest contributions.

On the day before Christmas some years ago, one nurse, according to her custom, made her first visit of the day to Mrs. M, a patient in the terminal stage of her illness. The patient's nights were bad and early care refreshed her for the day. On this particular day, however, our nurse found that Mrs. M

had spent a sleepless, pain-racked night, the doctor had to be called, and he had administered an opiate which was just beginning to have its soothing results. So the nurse promised to return later in the day when the sedative's effects had worn off. For the nurse it was one of those bad days when everything goes wrong. Street cars were crowded and late. Families were too absorbed with their Christmas activities to make the usual helpful preparations for her visit. Patients were irritable and hard to satisfy. She found new and unexpected orders in homes where simple baths had been the usual procedures. The hours flew by and quitting time came before the nurse had finished her day's assignment. And there was still the return visit to Mrs. M. The nurse was tired, she had a long journey home before her, there was nothing in the rule book to say that a return visit must be made when the first offer of care had been refused—so being human, as well as professional, the nurse boarded the street car for home. She, too, had unfinished Christmas preparations for she was a widow with two children of her own. As she prepared their evening meal, she kept thinking and thinking of Mrs. M and how she had failed her for, no doubt, this would be her last Christmas. So after the children's dinners were served and they'd been admonished to go straight to bed as mother had an errand to do, this nurse again donned her uniform, and, with black bag in hand, started her long ride across town to her unfinished duty. When the bath was given and the bed dressed in fresh linens for the morrow, Mrs. M said, "Now nurse help me down to the kitchen. I've got to dress and stuff the turkey. This will be my last Christmas with my family and it must be a good one—one they'll remember always." So the nurse got the patient into a warm dressing gown, stockings, and slippers and half dragged, half carried her to the kitchen and established her in a comfortable chair. She then began the tedious job of cleaning and stuffing the turkey. Only after all this was finished to Mrs. M's complete satisfaction, and she was tucked safely again in bed, did the nurse return to her own home and her unfinished home duties. Was this contribution worth while? All I can answer is that though this incident occurred some years ago, each year at Christmas time there comes to our office a Season's greeting card and always there is written some message of appreciation for the skillful care and thoughtful service given by this nurse to a loved wife and mother.

THERE ARE MANY, many other contributions too intangible to point out and define. Perhaps Mr. X expressed best the kind of comfort brought by the nurse. Mr. X is an elderly colored gentleman who was referred to us some days ago. In making the referral, the social worker said that Mr. X had been taught, while in the hospital, to irrigate and dress his colostomy, but he seemed doubtful about the procedure, so she asked if we would visit him in his home for a few days to see that all was going right.

For the first three days the nurse did the irrigation and Mr. X never gave the slightest indication of a knowledge of the procedure. On the fourth morning the nurse asked, "Now, Mr. X, don't you think it is time you're beginning to learn to do this?" Mr. X looked up at her and in his voice was a bit of remorse for his deception, but a great deal more of pleading, as he said, "Miss Nurse, I do know how to do it. But please, please don't leave me now. You see I'm counting on you and God to see me through this."

In summary, then, to the medical profession the nurse is a professionally competent ally in the service of cancer patients. To the families of these patients the nurse brings relief and comfort by sharing the responsibility for nursing care and by helping to make the many adjustments necessary because of the nature of the illness. To the community she brings an intelligent interest and sincere efforts for prevention through promotion of sound health habits including periodic physical examinations, and an alertness in early recognition of suggestive symptoms. To the cancer patient she brings not only skill in her performance of nursing procedures, but, because she is interested in improving the quality of life, as well as the quantity, she brings an understanding heart which enables her to serve the whole man.

The longer we, of the Visiting Nurse Society, are associated with this group of patients the deeper is our realization that our opportunities for services extend far beyond the actual nursing care and are as many and varied as we have individual patients.

Public Health Nurse in the Cancer Program

By MATTHEW H. GRISWOLD, M.D.

THE CANCER control work in Connecticut has from the beginning been stimulated by the medical profession. In 1933 a Tumor Study Committee was appointed by the Connecticut State Medical Society "to survey the existing conditions and stimulate interest in the movement for cancer control, and to develop a program best suited to the needs of this state." In 1935 the Connecticut State Medical Society assisted in obtaining funds from the general assembly for the establishment of a Division of Cancer Research in the State Department of Health. This division was established in order to effect the integration of all individuals and facilities connected with the cancer problem, the Tumor Study Committee acting as an advisory and policymaking body.

Cognizant of the fact that adequate and accurate recording of pertinent data form the foundation of a cancer control program, the Tumor Committee with the advice and assistance of the Division of Cancer Research developed a standard tumor record form. This form combines the general features of a clinic and hospital record, and when completed becomes a detailed abstract of the patient's hospital history.

In 1941 a preliminary study was made of the records already collected from the hospitals then participating in the program. It was found that the standard record form and the code adapted for its transfer to punch cards had stood the test of time and plans were made to collect on standard record forms abstracts of the records of all patients hospitalized for cancer from January 1, 1935. The year 1935 was decided upon as a starting point because that was when the Division of Cancer Research was established, and it was felt advisable to begin the collection of particular information concerning cancer cases from the outset. At the present time there are 27 hospitals participating in the cancer record registry, representing about 90 percent of all the available hospital beds in the state. There are in the files of the Division of Cancer Research over 30,000 records of cancer patients. The information contained on these records has been coded and transferred to punch cards for statistical analysis. Of prime importance as a result of the establishment of this registry is the interest aroused among local physicians by the active campaign carried on to determine the status of all these patients with cancer. Some patients had not been actively followed up until the record registry began to function.

A number of Connecticut hospitals that do not maintain what is commonly accepted as a clinic do give their patients a rounded service regardless of financial status. The hospitals affiliated with the program accept cancer patients referred to them, and these patients are given the benefit of group diagnostic procedures and treatment is recommended and carried out. A few of the smaller hospitals find it necessary to refer cases for deep x-ray therapy or radium treatment to larger centers. Ingenious devices have been designed to urge patients, both ward and private, to seek frequent checks on their state of health.

Local and state welfare agencies take care of the cost of hospitalization of indigents. The sum of $50,000 annually was appropriated by the general assembly to the State Department of Health for "the study of cancer and the maintenance of diagnostic and treatment clinics." A part of this special cancer fund, administered by the State Department of Health and allocated to the tumor clinics, may be used to defray the cost of x-ray and laboratory procedures in the diagnosis and treatment of cancer. These funds may be used also to pay all or part of the

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salaries of tumor clinic secretaries, record clerks, and follow-up workers. It is recognized that a most important service to the cancer patient is effective follow up so that the patient may be brought back to the clinic or referred to his family physician for the frequent medical checks that are necessary in the treatment of cancer. About 90 percent of all cases admitted to the hospitals participating in the program are under constant follow-up surveillance.

As each record is made out in the local record registry in the hospital, a carbon copy is taken. These copies are sent to the Division of Cancer Research of the State Department of Health at frequent intervals. As these records arrive in the office of the Division, they are coded according to a classification agreed upon by the Connecticut Society of Pathologists and so are uniformly interpreted. They are then checked with the Bureau of Vital Statistics as to fact of death. An index card is then made out and filed in the general cross index.

If it is found that a patient has been to another hospital previously, the information on the new record is sent to the first institution to bring its follow up of that case up to date. It is possible for a hospital to obtain necessary information by telephone on patients that come to a clinic without adequate information concerning previous treatment.

The coded information contained on the record is then punched on an 80-line punch card and these cards are kept up to date as fast as new information comes in. The flow of work in the Division of Cancer Research is so organized that the records are indexed, coded, the cards punched, and the records filed within 48 hours after their arrival at the office of the Division, so that there is never an avalanche of unfinished record work at hand.

Analytical study of this mass data is being continuously carried on and numerous reports on the results of these studies have been made. Individual hospitals have sought and been furnished with statistical tables of cancer by site in order to help their own research. A recent study by the Division of duration from first symptoms to treatment shows that the medium time elapsing was 7.2 months.

The American Cancer Society is active in this state through its branch, the Connecticut Cancer Society, conducting a program of lay education and making grants to hospitals for carrying on research work and other purposes. All requests for grants from these cancer society funds are reviewed by a medical advisory committee.

The public health nurses of the state have shown a decided interest in the cancer program and have contributed measurably to the care and follow up of cancer patients. Numerous regional conferences for public health nurses have been held at which cancer and the Connecticut program were the topics of discussion. These discussions have followed a talk to the nurses by a representative of the Division of Cancer Research. The programs have been so arranged that several meetings on cancer have been held by the regional groups, taking up various phases of the problem in order. Cancer, the disease, is usually considered at the first meeting, then the medical aspects of cancer control, the Connecticut cancer control program, and the public health nurse's part in the program.

The functions of the public health nurse in the Connecticut Cancer Program may be outlined as follows:

1. *Case Finding.* Suspected cases are referred to physicians or persuaded to secure medical examination and care. The public health nurse occupies a strategic position, since she may note suspicious signs or symptoms indicating the possibility of cancer and so influence the patient to seek proper medical care at the earliest opportunity.

2. *Educational Follow Up of Known Cases.* In the process of following up cases of cancer, at the request of physicians or tumor clinic secretaries, the public health nurse acts as an educator. By advising prompt attention to any persistent abnormality, advocating the periodical physical examination, and distributing informative pamphlets, she can contribute much to the cancer control program.

3. *Nursing Care in the Home.* Some patients afflicted with cancer find it necessary or desirable to remain at home a part or all of the time. Many go to a hospital periodically for treatment or check-up examinations, remaining at home between visits, and terminal cases often prefer home surroundings to institutional care. The public health nurse supplies skilled care for these people in their own homes and can teach a member of the

family how to care for the patient in the interim between her visits.

4. *Mental Hygiene.* By helping the patient and the family develop a reasonable commonsense attitude toward the disease, the public health nurse can ease the emotional burden for many a household.

5. *Social Adjustments.* The nurse sometimes finds it possible to aid families in securing trained or practical nursing services in the home. She may also indicate to welfare or other agencies the need for dressings and other supplies.

6. *Transporting the Patient.* The transportation of cancer patients to and from hospitals or clinics is a problem that the public health nurse can sometimes solve. Occasionally it is practicable for her to transport these patients herself but usually this is the function of a neighbor or relative or volunteer aide.

The public health nurse plays an important part in the Connecticut cancer program. Through her close contact with the public, she is able to exert an influence that tends to bring about a fuller understanding of the cancer situation and the need for prompt and effective action whenever the disease is suspected.

POLICE METHODS CUT ACCIDENT TOLL

THOROUGH POLICING and investigation plus follow-through, methods employed by the Federal Bureau of Investigation, resulted in the reduction of plant accident costs in the Winthrop Chemical Company, Rensselaer, New York by 52 percent the first year and 84 percent the first six months of the second year, it was revealed at a recent meeting of the American Pharmaceutical Manufacturers' Association.

Blayney Barton, director of industrial relations for the company and a former "G" man, reported the method. He cited support of the top executives as a primary requisite for any plant safety program, stating, "Only with their help and assistance is it possible to set up a safety organization, with proper publicity, adequate independent counsel and advice, money for safety installations, and equipment, and provisions for proper medical and hospital service. The company employs a full-time physician, a nurse, first aid men, and a new eleven-room hospital has been added to complete the safety equipment.

"Our number one safety procedure is investigate," Mr. Barton said, "——investigate every accident. The secret of our intra-organization success lies in our system of immediate accident investigation and the follow-up action taken.

"Check-up investigations are conducted by the company's own chief of police. He obtains a report on accidents from the plant hospital, conducts his investigation independently of the affected foreman, and makes written recommendations which the foreman has an opportunity to review before action is taken. The primary responsibility for safety recommendations and accident control resides with the foreman, who in turn is directed by the safety committee and the experts in general charge.

"Experience has taught us that conditions which produce minor injuries in the first instance recur when allowed to go uninvestigated, causing serious accidents."

Next to investigation in importance in a safety organization is that of following through. The necessity of carrying through on all suggestions and recommendations cannot be overemphasized.

The company gives a president's award each year to the employee who made the greatest contribution to the company. The first such award was given in duplicate to two employees whose quick action saved a fellow worker's life.

Mr. Barton reported further that much care is taken in planning monthly plant safety meetings attended by department heads and designated foremen and workers, including office help. Another FBI technique Mr. Barton follows is keeping up a complete filing system, to permit supervision of both individuals involved in accidents as well as the type and place of the accident.

Filing in Public Health Nursing Offices

Report of the Subcommittee on Filing of the NOPHN Records Committee*

IS IT OPEN hunting season again? Are you hunting, hunting everywhere for that record, that paper, that you know must be somewhere in your desk or on your desk or just possibly under your desk? If you belong to those who are continually searching for the lost or at least temporarily mislaid article, or if you are just interested in learning how filing could and should be done, here are our suggestions for FILING SYSTEMS that really work.

Since nothing directly concerned with filing had been published by the National Organization for Public Health Nursing since 1933,** a Subcommittee on Filing was appointed in 1945 by the chairman of the Records Committee to gather and present ideas.

Members of the subcommittee decided that 10 kinds of material involve filing procedures:

1. Family folders, case records and auxiliary materials
2. Personnel records
3. Correspondence
4. Minutes and reports, committee meetings, citizen participation meetings, monthly and annual reports, staff education meetings, reports of studies
5. Publicity files
6. Books for professional education
7. Periodicals and pamphlets for professional education
8. Literature for distribution to patients
9. Bookkeeping material, requisitions, order blanks, bills, cancelled checks
10. Inventory of furniture and other supplies

*Members of Subcommittee on Filing: Isabel L. Towner, Chairman, formerly librarian, National Health Library, retired; Mabel E. Clough, director, New York Records Installation Department, Remington Rand, Inc.; Hedwig Cohen, educational director, Instructive Visiting Nurse Society, Washington, D.C.; Marion Ferguson, public health nursing consultant, USPHS, Chicago, Illinois; Rosalie I. Peterson, nurse officer, USPHS, Washington, D.C.; Edith Wensley, assistant director, NOPHN; Dorothy E. Wiesner, secretary, statistician, NOPHN.

**National Organization for Public Health Nursing. "Filing Methods in Public Health Nursing Organizations." PUBLIC HEALTH NURSING, April 1933, p. 207.

FAMILY FOLDERS, CASE RECORDS

The use of family folders in public health nursing is recognized and practiced as one simple way of emphasizing family health. Both active and closed individual case records are kept in family folders.

The most usual method of filing family folders is alphabetically by the name of the head of the household. If there is more than one folder for the same name, the sequence should be by initials of the name. For example, Smith, Richard Albert; Smith, Richard William. The strict alphabetical sequence will save much time in finding folders.

Some agencies keep their family folders according to year of last closing and alphabetically within that year. Either way may be justified. If one strict alphabetical file is used, a person seeking the folder need look only in one place. Weeding out old material, however, takes a long time. If the year of last closing is considered, one must look in five or more places for a family folder but weeding out old material takes less time. A general suggestion about filing closed case folders is that the simpler the filing plan the better for saving time of nurses and clerks. Every drawer should have a label on the outside showing what material is in the drawer. The closed files should be indexed with alphabetical guide cards using a card for about every 15 folders.

In some nursing services closed family folders are filed by diagnosis. This is particularly true in nursing services in which a great deal of tuberculosis and venereal disease work is done. From the point of view of filing this is not a desirable practice but is sometimes unavoidable even in departments with generalized nursing services. Active family folders are very often filed in a box on the desk of the nurse who is responsible for visiting in the homes of the patients. If the nurse is carrying a very large case load with many families

which need to be visited not more than each quarter, the active records will be too bulky for the nurse's box. In such instances, special file drawers for each nurse's active cases will be necessary. If the case load of a nurse is larger than 50, the filing of the folders in each nurse's box or drawer according to alphabet is helpful. Some agencies find that letter size folders are more efficient than the smaller family folder because the letter size folder eliminates the necessity of folding records and correspondence for filing and unfolding them for reviewing cases.

Individual case records, both closed and active, are kept in the family folders. When a case is being reopened from the closed files the entire material is best kept in the box or drawer of active records. The nurse, however, as she goes into the home will take only the records which she needs. The use of a family data sheet in connection with case records saves repeating family health problems on the record of each member of the family and is an aid to the nurse for reviewing the history of the family. The family data sheets could well be kept in the front of the folders.

If after a number of years the material becomes very bulky, the use of summary sheets may be resorted to. Correspondence concerning the family is best kept in the family folder. Services that use case records for teaching students are unwilling to destroy correspondence and old records. Sometimes the oldest correspondence can be transferred to inactive files rather than destroyed. Referral slips are similar to correspondence since they indicate the use of other resources in the community. Referral slips and social service exchange blanks are also useful in the family folders.

A tickler file of 5x3 cards arranged according to the dates on which the nurse plans to revisit the family is a necessity if the active family folders are filed alphabetically. Each nurse should have a set of 5x3 month guides and one or two sets of 1-31 day guides.

An auxiliary file found necessary in many public health nursing offices is one for index cards. The index card is usually 5x3 and is filed by the name of the patient. Lines are provided for identifying data and for dates of openings and closings. Some agencies, however, make good use of *family* index cards. The family index card is usually larger than the individual index card since it must of necessity give more lines for opening and closing of cases. The filing of index cards should be strictly alphabetical and too much emphasis cannot be placed on *strictly*. All the L's together and all the M's together is not strictly alphabetical. The following may illustrate:

Pace	Samson	Spiegle
Palcich	Sanson	Sprague
Palmer	Seabright	Springer

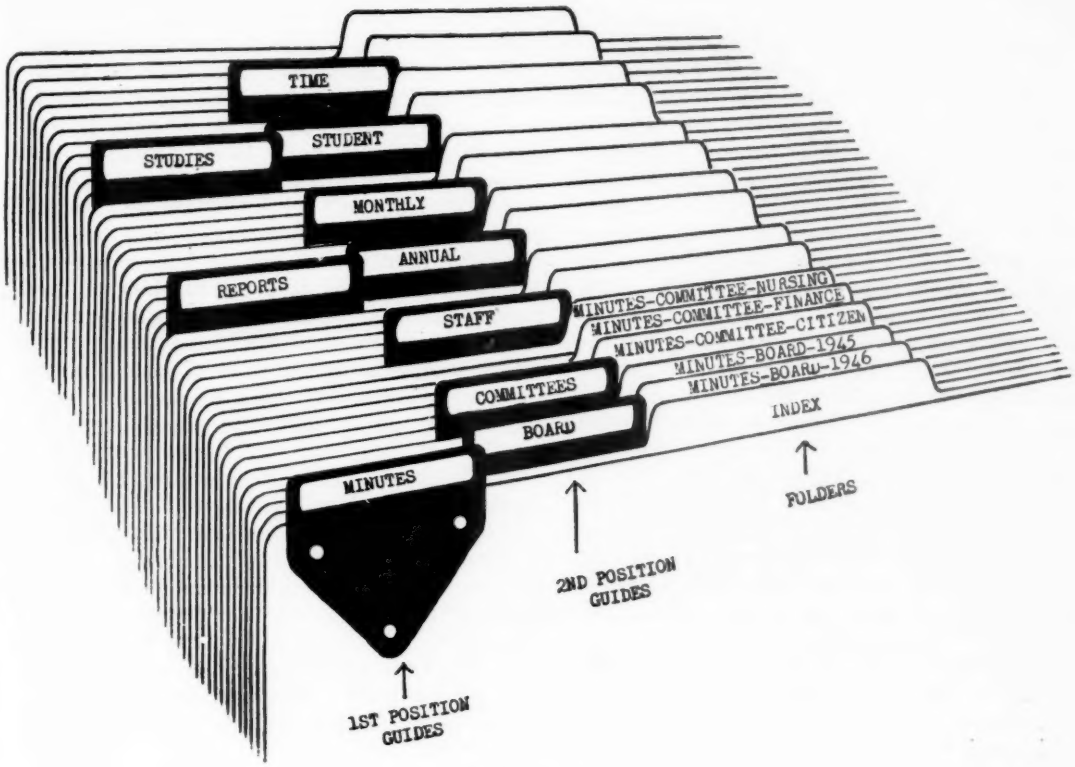
Alphabetical means unto the fifth and even the sixth letter. When one looks for the name of *Houghton*, it should not be necessary to look all through the H's or even all through the names beginning with Hough. So far as filing the Mac's and Mc's is concerned, library practice has found it advisable to put them all in one place regardless of spelling. The use of adequate guide cards to index the parts of the alphabet also cannot be overemphasized. A guide card for about every 30 to 40 index cards is recommended. It is often money saving to secure the advice of a reputable filing and indexing concern before setting up new files.

Large agencies have found Soundex filing useful but for smaller agencies this method has seldom been used. Soundex is a method of filing by phonetic sound. The value of this method is that confusion due to variations and errors in spelling are minimized. In the reading list at the end of this article is a description of the essentials of Soundex. Expert advice is needed to install Soundex filing.

A call slip file is another necessity. Practices about filing and keeping call slips vary, but the practice of entering at once upon a printed call slip the identifying information as it is received does not vary. In some agencies the call slip is destroyed when the record of the home visit comes through to show that the case has been taken up. In many services the call slips are kept from 3 to 6 months. In some services, particularly in official agencies, a notation on the reverse of the call slip is the only evidence in the public health nursing office that the home has been visited. In such cases the call slip is kept until further service in the family makes a more elaborate case record necessary.

PERSONNEL RECORDS

Personnel records, including application blanks, health examination blanks, employment histories, personnel policies, and student



Sample file drawer.

data are best kept in vertical filing drawers which can be locked. The contents of a file of personnel records will vary not only with the size of the agency, but also with the point of view of the nurse director. In small agencies, particularly those employing only one nurse, application and history cards for past and present workers should be filed in a definite place. The confidential aspect of the data should be assured. A looseleaf notebook of personnel policies with the dates of adopting the policies could well be kept with this kind of material. All health examination reports belong in this file. In large agencies the educational director will have her own files about student data. In small agencies the necessary student information can be considered part of the personnel record files. A set of all the reports received from or sent to the nursing schools and colleges should be kept. Material about a nurse employee can be kept very satisfactorily in a manila folder upon which appears the name of the nurse. Each folder will include all the material about that nurse. Material about students may also be filed in manila folders, arranged separately and alphabetically behind a guide card indicating that the material concerns students. All application blanks of persons not on the staff can be kept in a separate folder or folders.

CORRESPONDENCE

Correspondence other than letters directly concerning patients should be kept in vertical file cabinets. Letters to be answered could be kept in a pending folder on the nurse's desk. Material to be filed should have the place of filing written so that it can be easily seen on the top sheet. Principles of alphabetical filing should be considered. Decisions need to be made about the retention period of certain letters. For example, if a nurse writes for a sample of a record form there is no need of keeping a carbon copy of the letter after the form arrives. On the other hand, the necessity of having a carbon copy of important letters is evident. The use of volunteer assistance for the writing of letters and filing of material is recommended in a small agency not employing any clerical help. The handbook, *Progressive Indexing and Filing*[6] will be found helpful. Many agencies file all correspondence

with one service, such as the NOPHN, U. S. Children's Bureau, U. S. Public Health Service and the state health department, in one place under the name of the service or agency, rather than by the name of the individual who wrote the letter. If correspondence is taken out of the office or if more than one person in the office is using correspondence, it is necessary to establish a method of charging out the material. This is most easily done by using a colored card, size 8½x11, upon which is written the name of the person taking out the material, identifying information about the material, and the date on which it was taken. The charge out card should be placed in the file in the location from which the material has been removed. The charge out card serves as a control and a tracer for missing papers. The borrower is responsible for the papers until they are returned, at which time the date of return is entered on the charge out card which can then be used again for the next entry about removal of correspondence from the files. Correspondence with board members and other persons in the community can be kept in alphabetical order in this kind of file. A 5x3 card file giving the names, addresses and telephone numbers of persons, firms, or agencies consulted often is a great help. These 5x3 cards should follow the same alphabetical order used for case records and correspondence.

MINUTES AND REPORTS

Minutes and reports of committee meetings and citizen participation meetings, monthly and annual reports, reports of staff education meetings, reports of studies constitute almost a diary of the nursing service. In nonofficial agencies the secretary of the VNA will often write the minutes of the board meetings and see that they are kept in consecutive order. Copies of these should be in the files in the nursing office from the inauguration of the service to the last meeting. In health departments this kind of historical material is often not available in the nursing bureau. Minutes of group staff meetings, of all staff education meetings, and of study groups will prove useful when choosing new fields of study and also for historical purposes. This kind of material is best kept in vertical files according to the subject of the committee and arranged in chronological order within the folders. In this part of the vertical file copies of monthly and annual statistical and narrative reports as submitted to the board or director of health can be kept. The subject of the material to be filed should be written on the first page of each report. Each subject should have an individual folder, properly labeled to show its contents, and arranged alphabetically in the file drawer. A small subject file of one drawer can be indexed with alphabetical guides (A-Z) but more than one drawer of subject folders will need guides showing the captions of the major subjects. Guides with blank tabs should be supplied so that the names of the subjects may be typed to suit the needs of the file. Guides with tabs in the first and second position should be provided. The first position tab should be used for the main captions and the second position tabs for the subcaptions. For example: Minutes, with a first position tab, is a main heading. Board, with a second position tab, is a subheading of Minutes. All folders for minutes of board meetings would be filed behind the guide of that title. The folders should be labeled to show the main heading first, the subheading, then the folder heading, as shown in the examples in the illustration.

PUBLICITY FILES

In the publicity section of the files a folder with an appropriate label might be given to each of the following: case stories, testimonial letters, ideas for speeches, ideas for annual reports, for exhibits, radio ideas, publicity helps from sources outside the agency, a scrap book of local newspaper clippings concerning tne nursing service. When the public health nurse is asked to make a speech or be interviewed on the radio or to prepare a window display, germs of ideas will be there in the files. In the folder entitled "Publicity help from sources outside the agency" will appear notations as to where to secure motion pictures and film strips, posters, and special leaflets.

BOOKS FOR PROFESSIONAL EDUCATION

Every public health nurse has made her own choices about books for professional use and the arrangement of the books personally owned is also according to her own choice. Differentiation is necessary between books owned by the nurse which she keeps in her office, and between those paid for by the funds of the nursing service. Books belonging to the office should be cataloged. The name of the agency

should be written or stamped in at least three places throughout the book, not on the type. If the agency owns them, the material should be available to staff, board, citizens' committees, students, and perhaps others. Many agencies have adopted very simple library schemes for their books. They paste an envelope in the back of the book in which a card designating the book is inserted. Anyone borrowing the book writes her name and the date on the card and puts it in the charge box. When she returns the book she writes the date of return on the charge card and places the card in the envelope in the book. Agencies with this very simple method of caring for their books keep them arranged by subject matter on the shelves. They make 5x3 cards describing the books* stating the author, name of publisher, and other data. These cards are filed alphabetically by author and are kept in a box on the desk of a responsible person. Educational directors find it helpful to index certain chapters within books. Material which will assist a student to understand what is meant by family health work is of great value and appears in chapters of a number of textbooks. If indexing of this kind is done, it constitutes a dictionary catalog. Such a catalog contains cards for books by author, by title, and by subject and answers three questions: (1) what material do we have by this author? (2) do we have a book of this title? (3) what material on this subject do we have? The establishment of and new entries for a dictionary catalog take time. Voluntary help can be used to great advantage, if a staff person will choose satisfactory subjects and indicate how she wishes the material indexed. An aid to an agency struggling with the problem of making books useful to the staff is a pamphlet written by Zaidee Brown.[2]

PERIODICALS AND PAMPHLETS

Periodicals and pamphlets for professional education, even more than books, keep the nurse aware of changing emphases. But unless a scheme for their indexing and filing is established, they do not serve their best purpose. The simplest handling of periodicals is to keep them on a book shelf readily available for the nurse's use. Each magazine should be arranged chronologically. Binders are available which will hold 12 issues of PUBLIC HEALTH NURSING. Other binders may also be purchased. Some agencies find it worth while to pay for the permanent binding of the magazines they consider important. These, of course, are the property of the agency and not of the individual nurse. For small monthly bulletins vertical files are useful. A manila folder shows the name of the bulletin and the folders are arranged alphabetically in the vertical file.

The simplest method of handling pamphlets and reprints for professional education is to write on each pamphlet a subject heading which will describe the material and to file the pamphlets in folders which will be placed in boxes or drawers. Deciding upon such headings takes thought. One approach will be found in a publication of the National League of Nursing Education entitled "Library Handbook for Schools of Nursing." On pages 47-189 of this book are subject headings used by the Bellevue School of Nursing library. It is too elaborate for collections in small agencies but offers suggestions. When library techniques are to be used in a nursing office it is very worth while to consult some librarian in the town. She will make the task of cataloging books and pamphlets more interesting as well as more satisfactory both to the professional staff and to the volunteer helping.

A 5x3 card describing each pamphlet is a useful addition to the dictionary catalog describing the books. Some nurses find that adding notes to the cards about the material as they review it is of great use at a later time.

LITERATURE FOR DISTRIBUTION TO PATIENTS

This kind of material is apt to be of all sizes and shapes. It is most satisfactorily arranged by subject; for instance, all material on measles together. This material should be kept near the field nurses' desks so that it will be convenient for them to use. It can be kept in open boxes standing on a book shelf, or in piles on cupboard shelves or on sloping shelves with edges. Stocks must be reviewed and renewed frequently. It is sensible to note the date of receipt of a quantity of a pamphlet and to ask the nurses taking copies for distribution to indicate this on a stock sheet used for the purpose. This will help to determine turnover of material. The stock sheet may be 8½x11, and will contain a

*For an author card see entries in the list, p. 166.

place at the top for the title of the article, for the date when it came to the nursing office and the number of copies received. In columns below this can be shown the name of the person taking out the material, the date, and the amount taken.

BOOKKEEPING MATERIALS, AND RECORDS

A source of help about bookkeeping is a 9-page mimeographed bookkeeping guide available from the National Organization for Public Health Nursing. This suggests classification of accounts and describes methods of accounting for cash and donations received, for disbursements, the balancing of receipts and disbursements with the bank statement, and the use of a petty cash box. In a non-official agency it is necessary to keep more bookkeeping material than in a health department. For petty cash a strong box with a satisfactory lock is necessary. Every time any money is withdrawn from a petty cash box, a slip of paper known as a voucher is substituted for the money. This voucher shows the amount withdrawn, the purpose of the withdrawal, the date of the withdrawal, who took the money. It should be signed by the person who took the money. These vouchers are kept in the petty cash box until the treasurer reviews them. Bookkeeping materials even though the treasurer does the bookkeeping are best kept in a safe in the agency office.

In large agencies clerks can do the actual entering of data in the books but the treasurer reviews the material, makes the monthly report to the board, and prepares the annual report of receipts and expenditures which should be audited periodically by a certified public accountant. The signed audited reports should be kept in the safe. When requisition and order blanks are filled in and sent to another department a carbon copy is useful to the person in charge. When the material is received the items are checked against the carbon copy. If the entire requisition is included the carbon copy may be destroyed. In non-official agencies bids received from printing companies should be filed in the bookkeeping section of the files according to the name of the firm. Receipted bills should also be kept in this way and reference made on them of the check number by which they were paid. Some services file bills chronologically according to date of payment. Cancelled checks should be kept for a minimum of 7 years. They are usually filed by number and kept in the safe or in a locked drawer of the files.

INVENTORY RECORDS

A 5x3 inventory card should be made out whenever a new piece of equipment is received. These cards make up a permanent inventory file, and are used for the yearly inventory check. They describe equipment, automobiles, and durable supplies. A description of each item, the date on which it was purchased and the amount paid for it should appear. Cards should give information about furniture, typewriters, adding machines, electric fans, lamps, files for correspondence and for records, step ladders, bookcases, scales, nurses' bags and bag equipment, clocks, desk lamps, demonstration equipment, basins. A business-like method of keeping inventory will save loss of material and confusion as well as clarify what material is owned by the service and what material is owned by the nurse.

CONCLUSION

All suggestions in the preceding sections have as their purpose the saving of the nurses' time and, therefore, more satisfactory service to the community. One can well see the need for clerical and volunteer assistance to the nurse. The Records Committee believes that these files are necessary and hopes that the suggestions have been worded clearly enough to help work out problems in agencies handicapped by lack of specialists in the fields.

SUGGESTED SOURCES OF INFORMATION

[1]Akers, Susan Grey. Simple Library Cataloging American Library Association, Chicago, 3rd edition revised 1944. 197 p. $2.25.

[2]Brown, Zaidee. The Library Key: An Aid in Using Books and Libraries. The H. W. Wilson Company, New York, 6th edition revised 1945. 146 p. $.70.

[3]Family Welfare Association of America. "Information at Your Finger Tips." *Highlights*, November 1945, p. 116. $.15.

[4]National League of Nursing Education. Library Handbook for Schools of Nursing. The League, New York, 1936. 264 p. $2.50.

[5]National Organization for Public Health Nursing. Bookkeeping Guide. The Organization, New York, 1937. 9 p. $.10.

[6]Remington Rand, Inc. Progressive Indexing and Filing. Condensed Course for U. S. Government Offices. Remington Rand, Buffalo, 1943. 66 p. $1.40.

[7]————. Soundex. Modern filing plan which groups names pronounced alike but spelled differently. Remington Rand, Inc., Buffalo, 1942. 27 p. Free.

NOPHN and Counseling and Placement

By AGNES FULLER, R.N.

OF ALL topics now being discussed by professional nursing groups, counseling and placement services stand close to the top. Questions asked headquarters and staff members in the field, however, indicate some confusion in the minds of members as to the philosophy and activities of the National Organization for Public Health Nursing in relation to these most important services. Clarification is essential if public health nurses are to participate intelligently in the promotion and backing of nationwide counseling and placement services.

At this point we may well review briefly the activities of the NOPHN in the field of counseling and placement. In the earliest annual reports and correspondence we find references to placements being made through the efforts of the headquarters staff. In 1922 NOPHN organized a Vocational Department to meet the heavy demand from the field for this service and in September 1923 appointed a full-time vocational secretary for the work. Even with her appointment the needs were greater than could be handled effectively in the headquarters office and further resources were sought. Board action resulted in an appropriation granted in 1927 which enabled the NOPHN to share in the placement service developed in collaboration with the social worker group. The Joint Vocational Service, as it was called, is familiar to many of our readers.

For the next 10 years counseling and placement of public health nurses were carried on through the jointly sponsored facility. Although placement fees were charged, the project was costly and it was apparent that the NOPHN could not continue long to underwrite its share of the program.

In 1931 five midwestern state nurses' associations organized a Nurse Placement Service with offices in Chicago. This agency expanded its service in 1938 to nationwide coverage for public health nurses. In the same year the Joint Vocational Service was discontinued and its public health nurses' records were transferred to Nurse Placement Service in Chicago. NPS carried on the bulk of placements of public health nurses until its closing on August 31, 1945. On September 1 the branch office of the ANA Professional Counseling and Placement Service, Inc., was opened in Chicago and NPS records of public health nurses were retained in the new office. This office announced that until further notice direct placements of public health nurses would be made on a nonfee basis.

In addition to the services which the professional nursing organzations have provided, other facilities for placement have always been used. From time immemorial nurses have obtained positions by means of direct application to agencies of choice, by referral from schools of nursing and programs of study, through government agencies, nurse registries, commercial agencies, and the like.

Since the first days of its inception the NOPHN has considered the provision of vocational information to public health nurses and prospective students an essential service. It has prepared and published articles and pamphlets on the subject. Statements of recommended qualifications for public health nursing personnel in the light of current practice have been revised and issued at five-year intervals. A list of approved programs of study in public health nursing have been made available annually. All nurses are familiar with the series of descriptive leaflets, such as, *The Nurse in the Industrial Field, Your Career—Will It Be Public Health Nursing? The Nurse in the Orthopedic Field, What Tuberculosis Nursing Offers You,* and the recently issued leaflet designed for nurse veterans, *Your Postwar Job.* Also a review of past

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issues of PUBLIC HEALTH NURSING Magazine will show periodic releases on the newest developments in the field, articles on trends and expansions in public health nursing services, notices of special programs of study, job openings, announcements of civil service examinations, and other pertinent information. While the published materials may not have been designated as vocational guidance material they are one of the resources upon which any counseling program is greatly dependent.

HEADQUARTERS office, too, has served as a clearinghouse for many nurses wishing help on various vocational problems, such as how to enter the field of public health nursing, planning an advanced educational program, determining upon a specialty within the field, and many personal problems of adjustment to the work. Thousands of such requests for guidance are received yearly and much time is given by the NOPHN staff to meeting these needs. This help may simply be the forwarding of special leaflets which answer the questions raised, or talks given at nursing meetings, or perhaps individual interviews held either in the office or in the field. A brief glance at letters currently received shows a broad picture of the types of problems and questions for which individuals are seeking help. Here are a few extracts from letters received in this office within the past few weeks:

Please tell me everything about public health nursing, as I want to be one.

I am a graduate from a hospital having only a daily patient average of 50. Do I need additional postgraduate experience to enter this field?

My husband died recently and I find I have to go back to work and support my 8-year-old child. Before my marriage I was employed with a visiting nurse agency for five years. I have never had any college work. Is it necessary to get it now, or can I find a job with my past experience?

I have my B.S. in public health and I've worked in several agencies, but somehow never seem to be considered as supervisory material. What should I do—go ahead and secure more preparation on a master's level, or is there really something wrong with me? Please, may I come in and talk this over with you?

Where can I get a job?

Will my experience in the army be counted as a field experience in public health service? I worked primarily in the VD service for the past two years.

I am 39 years old and am tired of doing general duty in a hospital. Am I too old to come into the field of public health nursing? Please advise.

Not all the answers are forthcoming from the headquarters office, as the facilities for adequate counseling are not available. Such counseling would imply collection of records, many personal interviews, and definite plans for follow up of each individual. However, as previously stated, as much help as possible is given and referrals are made to other persons or agencies for further counseling service.

Other related activities such as advisory and accreditation service to educational programs, recruitment, and promotion of good personnel policies might well be included because of their effect upon public health nursing placement. This article, however, attempts only to review the direct plans and activities of NOPHN in the counseling and placement field. NOPHN has since its beginning assumed as its responsibility the promotion of counseling and placement facilities for public health nurses as part of its program. It has been alert to their needs and has attempted, within the framework of its organization, to meet these needs. When facilities were not adequate it has explored, initiated, and appraised other resources as supplementary aids to existing services. The Advisory Committee on Vocational Counseling, approved by the general membership in 1938, is charged with the responsibility for this whole area of service to NOPHN members and for coordinating the efforts of this organization with allied groups concerned with the placement of public health nurses.

AS INDIVIDUALS we have followed with great interest, either through meetings of our state and district nurses' associations or through news and explanations in the various nursing journals, the development of the American Nurses' Association plan for a nationwide counseling and placement service for all nurses. We have wondered as individuals what it will mean to us, how it will be set up, what are the plans for financing it, and how long it will take before it is actually functioning. The program is gradually assuming shape and it is with real satisfaction that we note in the official directory of the *American Journal of Nursing*, February 1946, that 14 states have designated individuals as state counselors. As the national agency concerned with

the progress of public health nurses and public health nursing service, NOPHN, too, has eagerly watched the ANA plan emerge, is in full accord with its principles, and has participated in its development through representation on various committees. At headquarters, by agreement, all inquiries about public health nursing are referred to the NOPHN office. This time-consuming advisory service, NOPHN has been very glad to give.

During these past few years the NOPHN has also been interested in the extension of placement facilities under governmental auspices. It has watched the service which has been developed for social workers on the West Coast. Originally set up with the help of a strong professional advisory committee, this program was continued when all state employment services were transferred to federal control during the war period. The plan provided coverage from the San Francisco office for 11 nearby states. From reports received, both the communities and the individual social workers served have been well satisfied with results.

It should be pointed out that tax-supported placement agencies have always given some service both to professional and to practical nurses. From federal reports in 1939 we note that in a two-year period 18,000 graduate nurses applied for positions. During the same period 43,000 practical nurses, 3,000 office nurses, 10,000 social and welfare workers made application through these facilities. The NOPHN Advisory Committee on Vocational Counseling as far back as 1939 discussed the possibility of placement of professional nurses through public agencies and suggested that conferences be arranged with the staff of the United States Employment Service to explore the situation. In view of the huge cost involved in a comprehensive counseling and placement service and the fact that such a service is beneficial not only to the nurse being placed but to the community as well, the Committee expressed the belief that the expense for the project might properly be shared jointly by nurse and community. Public employment services exemplify this principle.

SINCE 1939 several conferences have been held with representatives of the USES. These conferences initiated by both groups, have served for exchange of information as to the types of problems involved, basic philosophy relating to placement and counseling, the needs in the field, and related subjects. The USES has not limited its study and plans to the needs of public health nurses but rather has considered the whole field of nursing, both professional and practical. They have discussed the problems involved with all the various groups representing the nursing profession and related fields of interest.

The New York City branch of the USES has been active in these discussions. Possibly this local interest has been due to the close proximity to the national offices. And due to the large number of nurses concentrated in the northeastern-coastal area, the problems have been more acute. In order to improve the quality of the service to nurses coming to their office and to serve the community more adequately, the administrative staff of the New York City USES has secured budget appropriations which enabled them to set up a special project for this purpose and go ahead rapidly with their plans.

In view of this development, the NOPHN included in its postwar plans a request for funds necessary to permit participation with the USES in extending their service to a regional area, on an experimental basis. This plan was approved by the National Planning Committee of the National Nursing Council and included in the Comprehensive Plan for Nationwide Action (Item III A-5 c). As yet no money has been secured for the project and active relationship of NOPHN to the USES Nurse Counseling and Placement Office has been limited to representation on their advisory committee.

The USES office has intensified its service in the local area and is gradually assuming responsibility for placement of professional nurses on a regional basis. They accept work orders and nurse applications from wherever received. More about the setup of the New York USES demonstration and the philosophy under which it works is planned in an article to appear in a later issue of the Magazine.

One of the most interesting things about the development of the USES project is its advisory committee. This group is representative not only of all fields in nursing but of hospital administrators, private physicians, social workers, lay people, and other interested groups. Regular meetings are held monthly

and have been most effective in helping to develop sound policies which embrace the interest of both the profession and the consumer.

Staff counselors and interviewers have been carefully selected and all are qualified in the field of counseling. Among the group there is one professional nurse with advanced preparation in the field of counseling. A nurse consultant, Jean E. Sutherland (PUBLIC HEALTH NURSING, February 1946, page 93), has been appointed to the project and is responsible for the technical supervision. An attractively furnished suite of offices has been obtained and 24-hour service is available. The office not only handles the placement of both professional and practical nurses but others in the allied fields, such as x-ray technicians, nutrition, and laboratory workers. There is no charge for this service.

The NOPHN is still trying to secure a budget which will make it possible to work more closely with the USES in extending its services on a regional basis for the placement of public health nurses. At the same time its active interest and cooperation continues in the development of the American Nurses' Association Professional Counseling and Placement Service. We believe such supplementary services as the USES is trying out will be needed and will be used. The cooperative efforts of all groups interested in giving counseling and placement service of a high professional quality are essential, if the nurses and the public are to be adequately served.

DIPHTHERIA WARNING

DIPHTHERIA is one scourge many of us thought overcome but four sets of material coming to NOPHN recently make a warning necessary.

1. The U. S. Census Bureau in a publication of January 30, 1946, states: "The death rate for diphtheria, which usually reaches its seasonal maximum in November, was 2.7 per 100,000 population or almost twice as high as the expected rate for the month. . . . The death rate for the first 11 months of the year was 1.2 per 100,000 population as compared with 0.7 for the same period of 1944." These figures cover by the sample method the entire United States.

2. The *Statistical Bulletin* of the M L I for January 1946 shows that among their policyholders the diphtheria death rate in December 1944 was 1.0 and for December 1945, 1.8.

3. The S.C.A.A. (State Charities Aid Association of New York) *News* for January 1946 reports: "During 1945 . . . provisional figures point to an upswing in the number of diphtheria cases (124) and deaths (13) in upstate New York, an indication of the urgent need for immunization of all children as they reach six months of age and again upon entry into school." In 1944 there occurred in New York State outside of New York City only 56 cases and 3 deaths.

4. In the 1945 Yearly Review of the NOPHN the difficulties of doing immunization work are mentioned because in so many families both mothers and fathers have been working, with the result that it is difficult to get permissions from the persons taking care of the children for immunizations. Furthermore, many clinics have not been able to secure physicians' services for immunization work. In some places nurses have been doing this. The difficulties of reaching transient population were often mentioned and of teaching families from other parts of the country to use the facilities of the local health services. It is rather a surprise to note the number of times that nurses report children have been neglected because all the adult members of the family were at work.

It is evident that all public health nurses visiting in the homes in which there are young children have a responsibility to question about diphtheria immunization and to urge that every child receive this necessary service.

D.E.W.

Visit-and-Case Studies

By DOROTHY E. WIESNER

TO THOSE who know the need for intensifying and extending health services, these studies of visits and cases among public health nursing agencies* will be of interest. The figures show what kinds of nursing services are receiving emphasis and arouse questions as to the reasons for the variations.

Among nursing services of municipal health departments, infant health accounted for the highest proportion of visits, 16.1 percent. See Table 1. School health visits ranked second. Acute communicable disease ranked third, not surprising since the control of such illness is a primary responsibility of the official agency.

Among nursing services in county health departments, also, infant health accounted for a higher percent of visits than did any other service, 15.8 percent of the nursing visits being for infant health. Preschool and school health services were second and third.

Nonofficial agencies showed a distribution of service very different from that in health departments. Home nursing for noncommunicable disease was their chief activity. About half of the visits in nonofficial agencies fell in this category. Infant health came second as to percent of all visits; postpartum care, third.

Combined services are those in which there

*Wiesner, Dorothy E., and Murphy, Margaret M. Visits and Cases in Nonofficial Agencies. NOPHN, November 1945. Mimeographed, 16 pages. 50 cents.

————. Visits and Cases in Nursing Services of County and City Health Departments. NOPHN, February 1946. Mimeographed, 11 pages. 50 cents.

TABLE 1. DISTRIBUTION[1] OF 12 KINDS OF NURSING SERVICE ACCORDING TO TYPES OF ADMINISTERING AGENCIES

Kinds of nursing service	Types of administering agencies			
	Percent in municipal health department	Percent in county health department	Percent in nonofficial nursing service	Percent in combination service
Infant health	16.1	15.8	17.4	20.7
Preschool health	12.5	13.1	3.8	5.0
School health	13.6	11.7	0.7	3.9
Adult health	3.1	2.3	1.2	2.3
Tuberculosis	11.0	8.6	1.3	6.6
Antepartum service	3.8	6.7	4.7	5.3
Delivery	0.4[2]	0.3[3]	0.2[4]	0.3[5]
Postpartum service	3.0	6.1	8.9	8.1
Acute communicable disease	13.0	8.0	3.1	5.7
Venereal disease	4.2	4.8	0.4	1.8
Crippled children's service	0.8	2.2	1.3	1.6
Noncommunicable disease	9.6	6.4	48.8	34.4
Number of agencies included in sample	70	87	198	26

[1]Expressed as a percent which visits for each kind of service were of the total visits in the year 1943. The median figures among the agencies reporting the service are used in this table.

[2]Five of the 70 municipal health departments reported delivery service.

[3]Twenty-two of the 87 county health departments reported delivery service.

[4]Eighty-two of the 198 nonofficial nursing services reported delivery service.

[5]Nine of the 26 combined services reported delivery service.

is coordination or amalgamation of official and nonofficial nursing services to bring about unification and economy of effort. The combination programs studied were similar to the nonofficial programs in that their chief activity was noncommunicable disease, 34.4 percent of visits being for such service. Combined programs carried infant health service, and apparently emphasized this as strenuously as did the health departments, but with a relatively lower emphasis on preschool and school health. The percent of venereal disease visits in this combined service column seems unduly low when compared with similar figures in health departments.

Table 2 showing visits per case brings out significant variations. In both city and county health departments, the average number of visits per case for all services was about half that among nonofficial and combined agencies. This is due in great part to the fact that only a few health departments provide nursing care of the sick. A glance down the columns, however, shows that for every kind of service the nonofficial agency averaged more visits per case than did the health departments.

Among combined services the average number of visits per case was higher than among health departments but lower than among nonofficial visiting nurse services. The emphasis upon bedside care among combined services seemed evident from the high number of visits per case for postpartum service and for noncommunicable disease. For tuberculosis, antepartum service, venereal disease, and crippled children's work, so far as visit-per-case data were concerned, combined agencies appeared more like health departments.

Interesting and sometimes perplexing variations appeared among the figures submitted by the nursing services whose figures were used in these studies. Medians are used for comparison rather than arithmetic means as they picture more adequately what a large group of the agencies are actually doing. The range between high and low in regard to many of the services was very marked and "means" would tend to reflect these extremes.

Upon request, the National Organization for Public Health Nursing will indicate on a mimeographed copy the place of any agency whose figures were used.

TABLE 2. VISITS[1] PER CASE PER YEAR IN 12 KINDS OF NURSING SERVICE ACCORDING TO TYPES OF ADMINISTERING AGENCIES

Kinds of nursing service	Types of administering agencies			
	Municipal health department	County health department	Nonofficial nursing service	Combined service
Average, all services	2.5	2.2	5.1	4.7
Infant health	2.7	2.6	4.1	4.8
Preschool health	2.3	1.9	2.9	2.9
School health	1.9	1.9	3.4	2.5
Adult health	2.0	1.9	4.0	4.0
Tuberculosis	2.7	3.0	4.5	3.0
Antepartum service	2.8	2.3	3.0	2.5
Delivery[2]	1.0	1.0	1.0	1.0
Postpartum service	2.7	2.1	4.3	5.7
Acute communicable disease	2.0	2.0	3.4	2.6
Venereal disease	2.7	2.3	3.6	2.8
Crippled children's service	3.0	3.0	6.3	3.7
Noncommunicable disease	4.0	2.7	7.8	10.2
Number of agencies included in sample	45	53	143	23

[1]Measured by the median visits per case among those reporting usable data.
[2]By definition, each delivery attended by the nursing service is counted as 1.0 visit.

Prostitution, Promiscuity, Venereal Disease

By LT. (jg) WILLIAM GEORGE GOULD, H (S) USNR

"VENEREAL DISEASE is but one bitter fruit of promiscuity," Vice Admiral Ross T. McIntire, surgeon general of the U. S. Navy, has said, "and is perhaps less important than any other." Prostitution and sex delinquency are the prime spreaders of venereal disease. More important, they are a health, social, and economic threat to the American family.

Girls and women do not deliberately choose and prepare for prostitution as their vocation. They drift into prostitution or carry on sexual relationships outside of marriage because of environmental, economic or personal circumstances, and because of inadequate mentality, psychic conflicts, and other causes. Available studies reveal that the majority of promiscuous women come from broken or unhappy homes and frequently from low income families.

The more we learn about prostitution, the more we realize that the line between prostitution and promiscuity is difficult to draw. The "pick-ups" who loiter in taverns or hang around street corners present many of the same problems as the prostitutes who trade or sell their services. They are both carriers of venereal diseases. They both represent breakdowns in social organization and individual adjustment. Several years ago the largest percentage of venereal disease infections came from prostitutes.

MANY PERSONS believe segregation of prostitutes in regulated or controlled "red-light" districts protects the community from venereal disease. The argument of the underworld is that segregation decreases venereal disease through regular periodic medical examination of commercialized prostitutes and treatment of those found infected. This argument has proved to be not valid. Medical inspection does not and cannot assure freedom from disease. It does create a false sense of security for the men who patronize such places. Dr. F. C. Gillick, surgeon of the United States Public Health Service, states:

> A physician who certifies prostitutes as non-venereal or non-infectious is either intentionally dishonest or grossly incompetent. A prostitute can transmit gonorrhea, syphilis and other venereal diseases without becoming self-infected. The average prostitute, to meet her financial obligations, must accommodate twenty men per day. It does not take a mathematical genius to figure out what a prolific spreader of venereal disease an infected prostitute can be. The average . . . amateur prostitute, at best, only contacts from three to five men a night. Her method is slower. Both are dangerous and practically 100 percent infected.

On June 9, 1942 the House of Delegates of the American Medical Association went on record with the following statement: " . . . Medical inspection of prostitutes is untrustworthy, inefficient, gives a false sense of security and fails to prevent the spread of infection . . . physicians who knowingly examine prostitutes for the purpose of providing them with medical certificates to be used in soliciting are participating in an illegal activity and are violating the principles of accepted professional ethics." At the annual session of the House of Delegates of the American Medical Association in Chicago in December 1945, the Reference Committee recommended reaffirmation of these principles, adding, " . . . and that the public health authorities and the medical profession of the country be entrusted with the responsibility of carrying them out."

A secret enemy document which fell into American hands shortly after the liberation of Paris revealed the futility of the Germans' attempt to curb venereal diseases through controlled brothels. An elaborate system of 42

Lieutenant Gould, on leave of absence from the American Social Hygiene Association, Division of Legal and Protective Services, is on active duty with the Navy, now assigned to the Bureau of Medicine, Navy Department, in Washington.

brothels was set up, a prophylactic station was situated in or near each house, and each of the girls was inspected twice weekly. The captured papers disclosed that, despite all their precautions, from January 1, 1944, to August 16, 1944, there were 3,106 new cases of venereal disease in the Paris garrison of approximately 40,000 troops. Eighty-four percent of infections came from licensed professional prostitutes in the official houses. A number of studies show also that segregation permits a great increase in the number of contacts of the individual carrier and thus increases the probability of infection.

Another claim made by the racketeers is that the existence of a segregated area safeguards other women and girls against rape and seduction by providing a "normal sexual outlet." The argument sounds reasonable but the records show that segregation does not help local communities in policing prostitution or crime. Sex crimes do not increase when "red-light" districts are closed. Furthermore, delinquency breeds in commercialized prostitution areas. Families live next door to brothels. Children see a sordid life that may look glamorous and profitable. In the City of Honolulu, Territory of Hawaii, a controlled system of commercialized prostitution, with a gross income of from ten to fifteen million dollars a year, flourished for a number of years. On September 21, 1944, by direction of the Governor, the Honolulu police department closed the houses of prostitution. A year later police department figures for the 11 months just previous showed, in comparison with the same period for the year before when the brothels were open, a decrease in rape cases and in other sex offenses.

The prostitution interests state further that the closing of licensed and tolerated brothels causes prostitutes to scatter into the other sections or neighborhoods. This is known as the "scatteration" theory. This statement also is recognized as a fallacy by anyone who is familiar with the facts. Vigorous law enforcement reduces the activities of such women instead of scattering them. Such conditions cannot exist in the residential sections of a large city or in a small country town unless the police and public approve or are indifferent. The prostitution racket is a merciless exploitation of women for the profit of third parties, not the unfortunate girl or her male customer but the madam, procurer or panderer, the dishonest doctor, and other parasites connected with the business. Few people realize how the earnings of prostitutes are divided. Usually, the keeper or madam of a brothel gets 50 percent, the procurer or panderer 20 percent, and room, board, "medical" examinations and other expenses take 10 percent, leaving the prostitute 20 percent of her dollar.

In World War I venereal diseases were responsible for 357,969 casualties, 100,000 more than the number of men killed or wounded in action. They caused the loss of seven million man days to the U. S. Army. In the first two years of World War II the Japanese killed 36,000 Americans; syphilis killed 33,000. Selective Service figures revealed that 95,000 of the first 2,000,000 men were rejected because of syphilis. Every year thousands of people die of syphilitic heart disease. Between 8 and 10 percent of all admissions to the mental hospitals and institutions are due to paresis, a disease of the brain caused by syphilis. The syphilitic insane and blind cost the taxpayer 41 million dollars annually for care and treatment.

The two most important venereal diseases, syphilis and gonorrhea, are usually spread by sex contact. Syphilis is treated with the arsenicals and heavy metals, or the newly discovered drug, penicillin, or all three. In the *Journal of Social Hygiene* for December 1945, Dr. Walter Clarke writes:

> Under the old methods of syphilis treatment requiring a year or more of therapy, reinfections with this disease were rare. With new intensive methods, including penicillin, reinfections are relatively common. . . . All that one can do now is to state that the immediate effects of penicillin therapy are excellent and that these effects justify the hope that penicillin cures some cases of syphilis and does it without harmful toxic side effects.

In regard to gonorrheal therapy with the sulfonamides or penicillin, Dr. Clarke writes:

> It is possible to state with certainty that today gonorrhea can be cured with only brief treatment with penicillin, in fact 200,000 units of penicillin given in a period of a few hours has cured most cases. . . . We know that only a few years ago the sulfa drugs were hailed as curing 85 to 90 percent of cases of gonorrhea. Now the results are rarely much better than 60 percent of cures. Resistant strains of the gonococcus have become prevalent—strains that are not susceptible to the attack of the sulfonamides. May this not also happen with penicillin? . . . Under

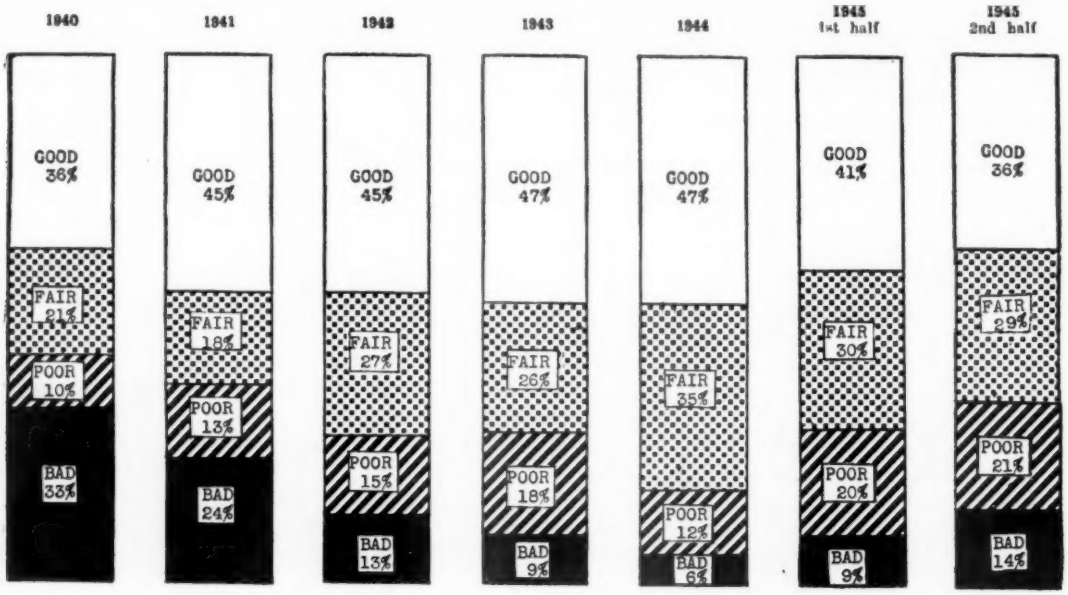
penicillin treatment a person can be cured of gonorrhea and get a new infection, all in the period of one week. As a matter of fact case records in rapid treatment centers and clinics abundantly show that many patients are infected over and over again.

In treating patients having a venereal disease an active attempt should be made to find and treat not only the infected person, but all other persons who have had contact with the patient during the known period of communicability of the disease.

ON JULY 9, 1918, largely through the efforts of the American Social Hygiene Association, Congress enacted the Venereal Disease Control Act which created the Division of Venereal Diseases in the United States Public Health Service. This new Division was charged, among other duties, with the responsibility of cooperating with state boards of health in the control of venereal diseases and in the prevention of the spread of these diseases in interstate traffic. The federal appropriation provided in this Act was allowed to lapse in 1922, and the program of activities to a considerable extent was discontinued. In 1938 the venereal disease problem was again attacked on a nationwide scale when the 1918 Venereal Disease Control Act was amended by Congress, with the passage of the Lafollette-Bulwinkle Act, giving the U. S. Public Health Service funds for research, education, and for grants in aid to the states. Because of the need to strengthen the social protection aspect of the program, conferences were held in 1939 between the Army and Navy Departments, U. S. Public Health Service, State and Territorial Health Officers, and the American Social Hygiene Association, which resulted in the preparation of a joint statement dealing with official and voluntary measures for the control of venereal diseases and the repression of prostitution in areas where armed forces or national defense employees were concentrated. This statement, known as "The Eight Point Agreement," was accepted at the conference of State and Territorial Health Officers held in Washington in May 1940. In March 1941 the Federal Government established, as an integral part of the wartime social protection and venereal disease control program, the Social Protection Division of the Office of Community War Services in the Federal Security Agency. The new agency stimulated and aided in the development of programs for the repression of prostitution and promiscuity, correction of the conditions contributing to sex delinquency, and for the re-direction of sexually delinquent persons. Special hospitals or units in general hospitals for the rapid treatment of venereal disease patients were established by the USPHS in the majority of states under the emergency provisions of the Lanham Act, which permitted use of federal funds for community facilities necessary to the prosecution of the war.

During the early part of the war the Federal Bureau of Investigation, at the request of the Secretary of War and state and local authorities, sent agents into two states to put into effect the May Act, to repress prostitution in the vicinity of army camps. The federal May Act, an emergency measure suggested by the American Social Hygiene Association, was enacted into law in 1941, and will expire on May 15, 1946 unless reenacted. Also it is important to note that funds for the work of the Social Protection Division of the Federal Security Agency will run out on June 30, 1946. Unless Congress provides for its continuance the program will end on that day. The National Sheriffs' Association and the International Association of Chiefs of Police adopted resolutions condemning the toleration of prostitution in the United States. The Army and Navy intensified their program for venereal disease control particularly in the field of education, case-finding, prevention, treatment, and reporting of alleged sources of infection to civilian health authorities to supplement the work of the federal agencies. The American Social Hygiene Association, national voluntary health agency in this field, enlarged its staff and increased and expanded its educational activities and field studies of conditions in the country. The cooperation of associations representing the owners and operators of taverns, hotels, tourist camps, and amusement places was also received in this fight.

The coordinated nationwide attack on vice and venereal disease has helped to produce some excellent results. Police departments, with the backing of public opinion and the cooperation of the Army, Navy, Federal Security Agency, American Social Hygiene Association and health authorities, during the wartime period, were able to stamp out com-



Progress in repression of commercialized prostitution—an analysis of a series of 2,276 studies made by the American Social Hygiene Association, January 1, 1940-December 31, 1945, in 1,170 communities near which members of the armed forces are stationed.

mercialized prostitution. "Red-light" districts and houses of prostitution were abolished in more than 700 communities. The lowest wartime venereal disease rate in the history of the armed services was achieved.

LAWS ARE the foundation on which public health and social protection programs can be built. Venereal diseases cannot simply be legislated out of existence. There must be good laws, public support, and vigorous enforcement. Generally speaking there are four types of legislation and legal provisions relating to social protection and venereal disease control, which are of special current interest to the public. These include laws for the repression of prostitution, premarital and prenatal examinations for syphilis, and venereal disease control laws and regulations. The federal laws of major importance are the Mann Act, which prohibits interstate and international traffic in women; the Bennett Act which penalizes the importation of aliens for immoral purposes and provides for the deportation of aliens engaging in the practice of prostitution; and the Lafollette-Bulwinkle and May Acts already mentioned.

It was not until 1925 that all the states had some type of law to protect the family and community from the moral and health hazards of commercialized prostitution. There was little improvement of these laws from 1925 to 1941, but excellent legislative progress has been made by a number of state legislatures during the past five years. As of January 1, 1946, twenty-nine states[1] and the District of Columbia had acceptable laws against most aspects of prostitution. Seventeen states[2] had laws against some of the activities of the prostitute and their exploiters. Two states[3] had laws considered inadequate.

In 1935, Connecticut passed the first premarital examination law, the essential provisions of which are now in operation in 32 states[4] and the Territory of Hawaii. The majority of states now require a physical examination, including an approved blood test for syphilis, of both the bride and the bridegroom and a certificate from the examining physician

[1]Arkansas, Connecticut, Delaware, Florida, Georgia, Kentucky, Louisiana, Maine, Maryland, Michigan, Mississippi, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Rhode Island, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, West Virginia, Wisconsin, Wyoming.

[2]Alabama, California, Colorado, Idaho, Illinois, Indiana, Iowa, Kansas, Massachusetts, Minnesota, Missouri, Montana, Nebraska, Oregon, Pennsylvania, South Dakota, Washington.

[3]Arizona, Nevada.

as a prerequisite to marriage. The general purpose of this legislation is not to prevent but postpone marriage while the disease is in a communicable stage (except in Massachusetts and Virginia). New Jersey, New York, and Rhode Island in 1938 passed the first laws requiring physicians or midwives to see that a serological test for syphilis is included as part of the examination of every expectant mother seeking medical care. Thirty-five states[5] and the Territory of Hawaii now have prenatal examination laws to protect the health of babies.

Adequate laws and state boards of health regulations for the control and prevention of venereal diseases are the legal instruments which enable the health authorities to deal effectively with syphilis and gonorrhea, as public health problems. During the past few years a number of states strengthened their venereal disease control laws, particularly in relation to the reporting, treatment, quarantine, follow-up, and finding of persons with an infectious venereal disease. Experience has proved that such legislation is an essential and important factor in maintaining a smoothly functioning venereal disease control program.

NOW IN 1946, there is evidence that racketeers and former vice interests confidently plan to reopen their houses of prostitution. Most communities are determined, however, to prevent such action. In some communities the decision between a clean town and an open town hangs in the balance. Commercialized prostitution has again become easily accessible in 50 of 181 cities in which conditions were good during the war years, according to recent surveys. The "victory girl," the juvenile delinquent, the promiscuous girl of today, faced with unemployment or other difficult situations in the future, may easily turn into a postwar prostitute. Although we have witnessed great advances in the medical treatment of the venereal diseases, they are not yet conquered. The armed forces report a rise in the number of infections since the end of the war. "We think we have problems now in venereal disease," says Medical Director J. R. Heller, Jr., chief of the Venereal Disease Division, United States Public Health Service, "but we have not seen anything to compare with the problems we will have in the immediate postwar period."

This means that America faces a critical period. The gains against commercialized prostitution must be held and further advances made in the war against sexual promiscuity. The weapons of law enforcement, social services, and medical treatment must be used vigorously but wisely. The community, schools, the church, and the home must be enlisted in the support of a program for the repression of prostitution, control of venereal diseases, and public education to develop social responsibility in all citizens.

In brief, four major principles must underlay this program if we are to achieve success:

Prostitution, sexual delinquency, and venereal diseases affect the lives of our people and the health and well being of our communities.

Good laws and public support for their enforcement provide a foundation on which a sound program can be built.

Medical treatment alone or the closing of brothels and punishment of offenders alone will not solve the sexual promiscuity problem.

Effective education of our youth for life in a modern world and a renewed emphasis on the social responsibility of all citizens are essential if there is to be an improvement of community life.

Dr. William F. Snow, chairman of the Executive Committee, American Social Hygiene Association, says, "Along with victory in war, tremendous gains have been made in the control of venereal disease and the prevention and repression of prostitution and related activities. Millions of young men have been kept disease-free to fight for the freedom of our country. Now, as they return, they have the right to demand the kind of communities in which they and their families can live decently. It is our responsibility to do all that is humanly within our power to assure those conditions permanently in communities throughout America."

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[4]California, Colorado, Connecticut, Florida, Idaho, Illinois, Indiana, Iowa, Kentucky, Maine, Massachusetts, Michigan, Missouri, Nebraska, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Dakota, Tennessee, Utah, Vermont, Virginia, West Virginia, Wisconsin, Wyoming.

[5]Arizona, California, Colorado, Connecticut, Delaware, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Massachusetts, Michigan, Missouri, Montana, Nebraska, Nevada, New Jersey, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Dakota, Utah, Vermont, Washington, West Virginia, Wyoming.

Health Education in a Housing Project

By JUDITH ABRAMSON, R.N. and DONALD K. FREEDMAN, M.D.

NO BETTER opportunity has ever occurred to study the problem of community health in relation to improved housing than in Federal Public Housing Authority projects developed during the present emergency. The difficulties encountered in planning for community health in housing projects has given rise to many new medical nursing and sociological aspects of public health.

The literature of the past decade reveals a vast amount of information concerning the relationship between health and housing, which points to the fact that even under relatively good housing conditions, health cannot be maintained at an optimal level without an extensive program of health education. It is also agreed that problems peculiar to housing projects require an approach totally different from the ordinary community.

One of the largest government housing projects for war workers, Copeland-Newsome Park, located between Hampton and Newport News, Virginia, is proving to be a normal community in every way. A total of 5,200 housing units were erected: 1,350 for the colored population in the area known as Newsome Park; 3,850 for the white population in Copeland Park. The units are compact frame houses containing from one to three bedrooms and are equipped with all modern sanitary facilities.

From North Carolina and other nearby states, there was a gradual movement of 18,000 white and 9,000 colored residents. These thousands of men and women were absorbed mainly by the local shipyard. Many were couples with one or two children. The estimated school age population is 7,000, in addition to which there are approximately 1,000 nursery school age children.

It is evident that a large percentage of these families formerly lived in substandard homes. Due to the government's urgent call for war workers, they had moved hurriedly and with but little of their furniture. What was brought with them was inadequate. Their most immediate concern was to settle in their new homes, adjust to their jobs, and plan for their children's education. The residents by and large seemed to take health for granted. Children were sewn into their clothes for the winter, infants were fed whole milk out of soft drink bottles and pots of green vegetables were boiled for hours. Housewives seemed to be left idle. Their repose was intermittently interrupted by journeys to the kitchen sink for purposes of expectoration of the "snuff" placed under their tongues. Babies were subsequently bathed in these same sinks. Relatively fresh painted walls were marred with careless splashing of grease. Coal stoves which served to heat the units distributed thick layers of soot. Gas stoves, electricity, and toilets were unexplained mysteries to some. It was found, for example, that showers were used for storage space or as receptacles for excreta elimination. A common dipper once used at the family drinking well continued to be used at the kitchen sink in place of drinking glasses. Worms were frequently treated by self-administered doses of turpentine and herbs in place of prescriptions. Although the number of occupants to a unit was limited by the Management, misrepresentation permitted as many as 15 to live in a two-bedroom unit. Lack of furniture seemed to present no problem as the floor was a ready substitute for bed or kitchen table.

Inspection of stagnant pools of water under or about a house was interpreted not as

Miss Abramson was public health nurse assigned by the USPHS to the Copeland-Newsome Park Project. Dr. Freedman, Surgeon (R) USPHS, was director of the Peninsula Health District.

malaria control but, rather, the removal of a nuisance by which children dirtied their clothes. The health officer's efforts to control the spread of communicable diseases by conducting school toxoid clinics were tolerated by many only as a necessary evil. Visits by the nurse were welcome just so long as she made no demands. Whatever were their ills, the cause was laid to the water, the climate, or their neighbors. Neither the sanitary facilities nor the modern conveniences offered by this new community appeared to hold any appeal for those in greatest need. The thoughts of these people appeared to be focused on returning to their native homes.

This element of the community, deeply entrenched in habits that caused alarm even to those residents of more fortunate background, presented the health department with a strenuous challenge. It called for a program of fairly rapid and intensive health education since it was anticipated that these migrants would leave the area at their earliest opportunity to return to their former localities. It was naturally assumed that there they would once again revert to health practices that are undermining the health of the nation.

SINCE THE health supervision of this new community fell under the jurisdiction of the nearby county health department, the problem of its responsibility was tackled by the health officer. Located three miles distant, the county health department was working under duress due to a shortage of personnel. The public health nurse who covered the area in which the project was developed was assigned this new community in addition to her normal county load and responsibilities. Space was made available for health department use on the project by converting two housing units, one in Copeland and another in Newsome Park. Each of these operated as a suboffice of the county health department.

Shortly after occupancy began, the Copeland Park Health Office opened on a part-time basis. Office hours were publicized during which immunizations and consultations were offered. The community responded eagerly and in overwhelming numbers to the immunization program. However, it appeared before long that they were unprepared for the more significant educational services and responded only to the tangible. Therefore, the obvious and immediate needs of immunization and communicable disease control were the essential phases of the program for many months.

Concomitantly, the health department serving Newsome Park was operating on a full-time basis. Emphasis was at once placed upon the control of venereal disease, the incidence of which was found to be characteristically high. A venereal disease clinic was established, in addition to which the community was served with a generalized program which embraced the control of communicable diseases including tuberculosis, immunizations, maternity, infant and preschool, and orthopedic cases, midwife supervision, and first aid. Since only one doctor is located on the project and studies indicated that there was inadequate infant and maternal medical supervision, a maternal and child health clinic was organized. It appeared before long that little preliminary work was necessary to develop clinic attendance. By their overwhelming response, it was evident that the colored population was accustomed to being served by clinics for health supervision.

Meanwhile, the total picture differed vastly among the white populace. The residents continued to be unaware of their need for guidance in health matters. Only a limited number of home visits were necessary to estimate that a large number of families, though living in standard dwellings, had alarming, substandard health and hygienic practices. The inertia evidenced in health matters by these many thousands of potentially health-minded people in need of guidance led the health officer to request the service of a full-time public health nurse. This resulted in the assignment of a United States Public Health Service nurse to Copeland Park.

The setup in which the nurse was to work was typical of a small local health department. It consisted of a district health officer and a county sanitary engineer. State consultants and laboratory service were available. The health department was prepared to serve a community which was seemingly unmindful of its needs.

REALIZING that community participation in the health program was essential to its success, the public health nurse attempted to stimulate interest in health activities by inviting the Girl Scouts to assist in the preparation of clinic supplies. Their enthusiastic interest made it expedient to create and rotate duties painstakingly among some 30 children who soon manifested an interest in the health department activities, word of which they carried into their homes and schools.

Recognizing the fact that a people so steeped in tradition and habit would be slow to accept, no less invite, changes in health matters, the nurse made an effort to approach the home through the children's organized groups, the schools. All of the 1,400 school children were therefore examined and a notice of the health department's services and schedule was given each child to take home. Children requiring correction of defects were invited to visit the health office with their parents for consultation.

Another activity employed to promote interest in the health department was that of first aid. Partly because of location, it became the habit of many to "drop by" the health office for this type of service which, although not encouraged, was permitted to continue as a channel through which other health knowledge might be disseminated. Attendance at immunization clinics multiplied proportionately with the growing awareness of the service available. As a result, the opportunities for case finding increased.

Because of the transitory nature of their residence it was the practice of many housing tenants to travel frequently to their permanent homes in nearby areas. The relatively high incidence of communicable diseases was considered to be a reflection of the habits of the community. The number of nursing visits for the control of epidemics was consequently high. The infantile paralysis epidemic of 1944 made it necessary drastically to curtail travel into epidemic areas. In a period of less than two months some 300 home visits were made, the majority to families returning from "polio-areas." Given an understanding of their role in the control of the disease the people showed little resentment when a house was quarantined for this reason. Rather, a community atmosphere seemed to develop as neighbors discussed their common fear and foe. Those who failed to heed the health department's cautions and either continued to travel or broke quarantine regulations were considered "traitors" to the community cause. Being transients and thus separated from their own families, local physicians, reliable neighbors, and familiar agencies, these insecure people welcomed the guidance of the public health nurse. This factor helped to promote the service with unusual rapidity.

IT WAS SIX MONTHS after the full-time health program was in effect and after the initial intensive groundwork had been laid before an awareness on the part of the community made itself felt. There was an ever-increasing demand for information regarding diverse health matters and it became the habit of many persons to come to the health office voluntarily. In proportion to the rapid development of the generalized services, however, the need for a broad program of health education became increasingly urgent. There remained countless families who had not been reached, who remained unaware of such vital matters as nutrition, safety, medical supervision, and simple hygiene in their daily living.

Whereas a feeling of mass insecurity had originally prevailed among the residents, due to problems of adjustment, signs of leadership and organization now began to evidence themselves in the field of recreation and education. With its fingers on the pulse of the community, the health department was aware that the opportunity it had been awaiting had arrived.

Although neither leadership nor organization had been directly fostered in the realm of health over a period of six months, the PTA, Girl and Boy Scout troops, supervised play groups, churches and their Sunday school classes, victory gardeners, athletic club, auxiliary police and fire departments, Cub Scouts and others had all had occasion to call upon their health department for guidance and, in some instances, direct assistance in the course of the development of their activities. These same groups had shown an earnest willingness to participate and assist in health department activities, by distributing health bulletins in times of

threatened epidemics and assisting at school toxoid and other special clinics, and at the health office itself.

Finally, however, a group was approached directly by the health department, with the purpose of having them promote health by their own efforts. Ways and means were discussed with this lay group which eagerly accepted the challenge of undertaking a broad program of health education with the guidance of the health department personnel.

WOMEN WHO had either graduated from Red Cross nutrition classes or otherwise showed interest in nutrition were invited by the public health nurse to organize into a nutrition committee. As their initial project they selected a "Food Fair" as an inviting, painless, and dramatic method of stimulating interest in improved nutrition, food preparation, and conservation. Through committee effort, with the guidance of the public health nurse, several thousand people witnessed 35 exhibits. These were contributions of such organizations as the Victory Garden Club, Boy and Girl Scouts, school, nursery school, athletic club, health department, Red Cross, and county tuberculosis association. The Park's community center was for the first time used for educational purposes and a precedent was established for further useful undertakings. Fifteen hundred school children were taken on field trips to the Fair and the theme of improved nutrition was followed up by classroom projects such as poster making, scrap books, themes, and essays. Consultations on nutrition problems were in more frequent demand at the health office. The formation of a homemaker's club was one result.

The Nutrition Committee enlarged its scope of activities. With money raised from raffles conducted at the Fair, they undertook to sponsor nutrition classes for adults and several Girl Scout troops. White rats were purchased for a school nutrition project. These permitted the children to experiment with the nutritive value of well balanced diets as against their own inadequate ones.

Interest and enrollment in home nursing classes were stimulated at the Fair and within six months a total of 56 women completed two courses instructed by the public health nurse. One class continued to sponsor the formation of another, by registration drives and by contributing equipment and visual aids for improved instruction. A health library was started by these alumnae, who contributed the books they purchased to the community library. Wall brackets for plants and other decorations were contributed to the health office by this group.

Graduates of these nutrition and home nursing classes formed the nucleus for a health club. They indicated two main desires. One was to meet for educational purposes, and the other was to cooperate with the health department toward improving community health. Ways and means of maintaining the interest and energy of this enthusiastic group were explored. A program of volunteer participation was evolved. Members gave their time as clerical assistants and as aides in the weekly immunization clinics and child health conferences. The formal organization of a nursing committee was an outgrowth of this group, which later undertook to equip the office with curtains and assumed the responsibility of scheduling their own services at clinics on a sound basis.

The PTA health committee awakened to the contribution that it might make in the school health program. Volunteers from this group were subsequently present at each school visit made by the nurse. Such assistance made possible an individual follow-up record form in the school whereby the health and the field activities of the nurse were recorded. The committee chairman sought other ways in which to cooperate with the health office. In a short time a project of equipping and fully supplying the school clinic was completed.

The active assistance and cooperation on the part of these residents themselves made it possible for the health department personnel to enlarge and improve their services. At the same time, members of various subcommittees began to recognize the need for a more compact organization, with broader plans. Consequently, the formal organization of a health club was undertaken by the chairmen of the three committees: nursing, nutrition, and PTA health. It was resolved to meet periodically with the public health nurse and health officer for guidance and to report committee activities to one another. The chairmen were to continue

meeting with their respective groups. All committees were to meet jointly on a bimonthly basis for educational purposes and group projects. A fourth committee on publicity was formed with the main purpose of preparing and disseminating information on all health matters. An executive secretary was appointed to serve as liaison worker between committees.

The health department was thus firmly integrated with the community and the active volunteer assistance permitted the field activities of the department's limited personnel to expand. Proportionately, the need for a second public health nurse became increasingly pressing. The health club undertook the responsibility of organizing plans whereby the community was to be approached on this issue by education, publicity, and solicitation. With the approval of the health officer and the moral and financial backing of the Park's resident council (a lay body representing community organizations), the area was successfully canvassed for funds which made it possible for the state health department to engage a second nurse.

In the course of the intensive publicity campaign "to sell the health department" and raise funds, the services of the department became better known and more greatly used. Interest and pride manifested itself so strongly that the residents undertook to paint the unpainted building white. The health club landscaped the grounds and, finally, the management redecorated the interior and provided other much needed technical improvements.

As a further step in maintaining and promoting the active interest demonstrated by the residents, the health club made use of its large membership by appointing a representative in every court throughout the Park. Responsibility rests with these leaders to stimulate interest in health matters in their own areas. This is accomplished by cooperating with and assisting the health department and the club in their aim to sow the seeds of better health and greater health knowledge for the people.

IT IS APPARENT that this is not a scientific article. It is, rather, an investigation into the possibilities of more effective health service and health education inherent in a housing project in which families are unified by similar background and interests.

The organization of interested community members who assumed a large part of the responsibility for the health and wellbeing of their neighbors resulted in a relatively rapid demand for as well as a great response to the services, such as preschool, well babies, immunization, and home nursing clinics, and x-ray surveys. It was as though no one wanted to miss any of the available methods of protection, and word spread about the Park much more rapidly than is the case in an ordinary community.

In health education, films were eagerly requested since they could be shown with the weekly feature at the community center. Consultations on behavior programs and health guidance for the entire family grew into a heavy and important service.

In the short period of two and a half years it has been revealed that the combination of education plus action has netted results. Many persons no longer here whose creativeness, ingenuity, and dormant capability in regard to health were first stimulated in Copeland Park have already reported back from their own home towns on the constructive health activities initiated there.

It is felt, therefore, that the importance of the health office in a housing community lies not alone in the quantity of service it performs, but rather in its ability to stimulate the community to accept responsibility for raising its own level.

In a large housing project, great opportunities exist for education through community organization. Cooperation and assistance may be secured easily if the proper approach is utilized.

Report on a Senior Cadet Assignment

By MARY GARDNER, R.N.

THE UNITED STATES Cadet Nurse Corps, with its provision for a six months period of advanced assignment after the completion of thirty months basic program, made possible some interesting experiments in the placement of third-year students outside their own hospitals. These assignments differ significantly from the familiar undergraduate affiliation chiefly in their time length and in the degree of responsibility assumed by the student. The senior cadet still has the protection of her student status, yet she receives an opportunity in supervised practice which might be compared to an internship. If the thirty months basic program is sufficient to teach the basic technical skills of nursing and to give the student an understanding of the function of her profession in the community, the final six months may be utilized for advanced practice in a variety of community services.

Experience with a visiting nurse service combines many desirable features for an advanced educational program which might be continued even after the Cadet Corps is dissolved. A public health affiliation is particularly valuable for students whose basic program did not include experience in a local agency or out-patient clinic, and the six months period is long enough for the student to acquire some skill in analyzing public health problems which can hardly be supplied even in schools which incorporate public health in the basic program. The visiting nurse service which gives bedside nursing unites the less familiar aspects of public health nursing with the physical care of the patient to which the student is already accustomed. And such an agency with a good supervisory staff provides two very necessary conditions for any educational program: independence for the student with intelligent guidance from her supervisors.

The student nurse in a visiting nurse agency learns the meaning of "cooperating with other agencies;" she sees public health problems and learns what can be done about them. She also learns what cannot be done. This latter knowledge tempers the fine rhetoric of graduation speeches and redirects amateur enthusiasm. Her efforts to "teach the patient" will reveal the student's own weaknesses. Patients are quick to sense uncertainty. And the student may be amused or resentful, depending on her temperament, when her cadet uniform provokes questions about her status and whether she is a "real" nurse.

The Visiting Nurse Service of New York with which I spent my senior cadet assignment period introduces the student to the service through a series of group lectures, local office conferences, and the individual supervision of a senior adviser, with whom the student makes her first visits into the homes of the patients. The senior adviser allows the student to participate in the nursing care very early in her experience and the student thus begins to learn the new details of her work by practicing techniques with which she is already familiar. The senior adviser interprets, explains, and demonstrates the material which is given in less detail in group lectures and conferences. She chooses patients whom the student may visit alone, reads the record the student writes of her visit, and gradually guides the student toward the assumption of more responsibility.

As the student begins to make visits alone her senior adviser helps her to plan her day's work. The senior advisory relationship is discontinued after two months and the student is then responsible for a selected case load of her own. During the six months the supervisory staff makes periodic visits with the student to evaluate her work and help her

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to see her needs and possibilities for improvement. At least six days are spent in the field with the student. A written report of the supervisory visit is read and discussed with the student and her own comments are often incorporated. These detailed analyses are a valuable part of the educational experience of such an assignment. Since they are also the method used in evaluating the work of the staff members of the organization the student does not feel that her work is being unduly scrutinized.

My introduction to the patients of the Visiting Nurse Service began on my first day with that organization. I went into miserable homes; I heard strange languages; I smelled new foods. I walked down a street whose sidewalks were covered with fruit and vegetable stands, where housewives bargained with the grocers, gesticulating over the fish, cursing the rotten apples. I went into the homes of those housewives and saw the pillows they had brought from the old world, saw the wedding pictures, the overdressed brides, the embarrassed grooms. I saw photographs of their sons who had gone to war and I read the letters they wrote home. I listened with delight to their strange broken speech and I felt for the first time the meaning of the "New World." I tried to understand what I must do here and I took a childish pleasure in the blessings invoked on the nurse as she walked down the street. I wished Thomas Wolfe might have accompanied the nurse and seen this varied life as intimately as he saw the small Southern towns. The dirty streets, littered with the debris of the daily living of thousands, lined by blocks of apartment houses, noisy with the rush of trolleys and elevated trains, filled me with a new excitement and I sought the secret of New York from the changing faces which I watched in endless procession. I sensed the tremendous pressure of crowds; there were moments when I felt a sudden insight into the driving fury of the mobs. There is an economic explanation, but I think not even scarcity nor multiplication and division nor supply and demand can explain the lusts and appetites which perpetuate this turmoil. Rather naively I wondered if there were not someone who had felt the pulse of the city, who understood the life force of her seething circulation. Then I looked at the crowds themselves and I saw that they read the same comic strips, movie magazines, and pocket detective yarns which are on the counters of the corner drug stores at home.

The young student whose ideas of New York are inspired by *The House on Henry Street* will be amazed to learn that visiting nurses do not spend all their time climbing dark stairways and going down into damp basements to seek out the neglected members of society. The visiting nurse offers a service which the entire community is learning to use. She goes into the comfortable homes of the well-to-do to give nursing care and demonstrate procedures to the family; she teaches young mothers to care for their babies; she visits patients following discharge from the hospital and helps both the patient and family through the period of convalescence. Since the Visiting Nurse Service functions in diverse economic areas, its patients include the secure as well as the economically insecure, and the young nurse need not feel that she is the less helpful to humanity if humanity can afford to pay for her services.

New York itself is a glorious adventure for one like myself who had never seen or heard a great symphony orchestra, never stood before a famous painting, never attended an opera. I tried to separate my impressions of wonder and delight before such beauty from the bewildered realization that this city is occupied by human beings such as I. Each day's work gave me a varied impression of poverty contrasted with the famous charms of New York. I saw a new city as well as learned new things about nursing.

The advanced student nurse has assumed all degrees of responsibility in her own hospital, a situation which is often more profitable to the hospital than the student. The financial guarantee of the Cadet Corps enabled students to seek advanced experience not available to them in their own hospitals, yet even without the financial sponsorship of the Cadet Corps reciprocal agreements between cooperating agencies might continue to provide these opportunities for the student. If the shortened programs now being studied are adopted, the advanced practice period may fill a real need for the professionally trained nurse. And if we agree on the public health basis of all nursing, then we must recognize that the public health assignment has a particular value, especially for the student who may have no other public health experience.

Applying the Orthopedic Principle

By CAROLYN BOWEN, R.N.

MY, WHAT a fine confident bearing that woman has!"

"Yes, doesn't she carry herself well? You know, she has been director of our Visiting Nursing Association for the past 25 years. And to all appearances she is as young and alert as she was when she just started on the job."

In contrast to these admiring comments, is the remark of G. I. Joe one day when the new major arrived on the ward for her daily rounds. "Boy, the gal sure looks beat up!"

Perhaps purely superficial observations, both, but they illustrate well the importance of good posture to a nurse and the reactions it creates among the people whose lives she touches, both privately and professionally. People expect a nurse to "look" as well as "act the part." She is engaged in the business of health and should be an outstanding example of the results of practicing, as well as preaching, the principles of positive health. The older nurse, mentioned above, inspires sick and well people alike with courage and enthusiasm for living, by her very manner. The young soldier cannot find this quality in the drooping head, round shoulders, and general look of weariness about the young nurse.

The word "orthopedics" originally in the early history of medicine meant the correction of deformity. In recent years, the trend in orthopedics, as well as in all phases of health work, has been toward stressing more and more the importance of preventing as well as curing a condition. Postural training has grown in the same way, from the curative to the more positive approach, that of prevention of deformity. The alert nurse readily recognizes this development and seeks to make a personal application of this knowledge.

What can a nurse do to improve her posture? Her first step must be an emotional one; that is, she must have a sincere desire for improving and maintaining graceful body attitudes if only from the standpoint of her own sense of well being. Next, she must familiarize herself with and understand the basic principles of body mechanics. In hospitals, orthopedic specialists are usually available for help along these lines. In nursing agencies very often there is an orthopedic nursing consultant. Then too, there is always opportunity for broadening one's knowledge through staff education. Usually books and pamphlets are available in hospital and nursing agency libraries which give elementary discussions of the scientific principles underlying posture.

Jessie L. Stevenson, in her booklet *Posture and Nursing,* has summarized very clearly what the essential points of good posture are:

> When the body is in correct alignment the head is balanced above the shoulders, hips, and ankles. The chest is up and the breastbone is the part of the body farthest forward; the lower abdomen is retracted and there is no exaggeration of the normal curves of the spine. The feet are parallel about three inches apart though the width of the stance varies according to body build. The knees are in slight flexion and the patellae point in the same direction as the feet. The weight of the body is borne through the center of the ankle joints. In the erect position the body weight must be maintained against the pull of gravity on a narrow base of support. When the body is aligned so that weight is correctly distributed or centered there is equal pull of gravity, and weight is balanced with a minimum of strain. Good posture in the erect position is maintained by the alignment of the bones which allows equal distribution of the body weight and by the constant tonus of the skeletal muscles. . . . . In correct alignment in the sitting position, the position of the head and trunk should be the same as that in the correct standing position. . . . . Correct alignment in the back-lying position does not differ from the alignment in the

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standing position, except that the body is in the horizontal instead of the vertical plane.

Finally she must work to achieve tangible results. Ten minutes a day (preferably in the morning) on general toning up exercises, performed with moderate speed and vigor will be helpful, but achievement of desired results is not attained by this daily ten minutes. The nurse must be aware of the individual characteristics of her own inherited body architecture. Through her intelligent imagination, she will appreciate the effect of stress and strain over a period of years on the nervous, bony, and muscle structures of her body. She will try to act accordingly, working out postural discipline to suit her own individual needs and applying the basics of good body alignment throughout the day in her work, her recreation, and her rest.

The hundred little acts that we perform unthinkingly every day, brushing the teeth, driving a car, walking to work, can be carried out as automatically the right way as the wrong. With a little conscious effort, whether we are standing, sitting, working with patients, or engaged in more strenuous activity, we can maintain top efficiency as well as give that impression of effortless grace that is so desirable. When we stand, we should stand as tall as possible, with the head, the shoulders, the abdomen, the hips and the knees in good alignment. When we sit, we should have the lower back well supported. In reading, the paper or book should be held at the proper distance and with sufficient light to prevent eyestrain. When carrying luggage, it should be changed from side to side frequently. When lifting patients in bed, our feet should be kept a little apart in the foot forward position to throw the bulk of the weight on our thighs instead of the low back area. And it is so important for nurse instructors to heed their posture when they are teaching classes of students. Also it goes without saying that, in competitive sports, correct stance often means the difference between winning or losing the game. In our own business and social life, we can often either make or mar the success of the occasion by the postural attitudes which we permit ourselves to assume. These are but a few instances of "carrying through" from our conscientious morning exercises.

HERETOFORE, the discussion has been concerned with the nurse's personal response to posture. But, in this modern age, nursing leaders generally agree that every nurse whether private or general hospital duty, school, industrial or public health, has an individual responsibility for health teaching. It seems that the forward-looking nurse must be a combination of the manual and the oral. That is, she must be able to work skilfully with her hands and at the same time be articulate enough to arouse in her patients a desire to prevent the recurrence of the conditions which she is tangibly helping to cure. The nurse need not be a specialist in orthopedic nursing in order to do a good job of preventing deformities in her particular type of nursing. A nurse with a knowledge of desirable postural habits and a passion for establishing them in her patients, will not only see, but will make opportunities to achieve this objective. This pertains to patients sick in bed either at home or in the hospital, hospital out-patients, and men and women at their places in industry or business. It includes all age groups and occupations, from infants, preschool and older school children to adolescents and adult men and women.

Let me describe a few situations showing successful results actually achieved by nurses conscious of orthopedic implications in various nursing fields.

In the dermatology ward of an army hospital, a number of patients were receiving treatment for a severe acne condition in which deep abscesses were present at the hair line of the neck and upper shoulder region. The nurse noticed that these patients carried their heads bent away from the affected side with the shoulders stooped, this position apparently being the one which caused the least strain and discomfort to their necks and shoulders. Realizing that this habit might eventually cause wry neck and a permanent round shoulder condition, if allowed to continue over a period of weeks, the nurse reported her observations to the ward officer who prescribed postural training in the physical therapy department of the hospital. The characteristic malposition of the head and shoulders was readily corrected.

In the same ward a patient had been con-

fined to bed for a number of weeks with a severe fungus infection on both feet. When he was finally allowed out of bed, he assumed a peculiar manner of walking on his heels, still protecting the areas which had been painful so long. The nurse helped him back to his normal walking habits by giving simple instructions as to how to put his weight on the entire foot. This former peculiar gait might have become habitual and made him abnormally self-conscious had his nurse not helped him to correct it when he first started to walk.

A district nurse received orders to give bedside care to an old lady of eighty who was confined to bed because of a heart condition. She was a maiden lady living with a bachelor brother, and the financial resources of both were about at an end. When winter came, so little money was available for fuel that it was a problem for them to heat the kitchen stove, let alone the bedrooms. One day, after several days of severe cold, the nurse found that her two charges had conquered the problem of the cold bedroom. The brittle old lady had pushed the pillows under her head, had brought her knees up to her chest and had her brother pile heavy cotton bedclothes on her to keep warm. They had conquered the cold, but the nurse soon found that her patient was unable to straighten out her legs. Even after a few days, she was beginning to have flexion contractures in her hips and knees, and her neck and shoulders were becoming rigidly stiff. The nurse helped them to secure fuel through a welfare agency and when the house was at a comfortable temperature some of the weighty clothing could be removed. By giving special care to the knees, shoulders, and neck of the old lady, the nurse gradually brought her patient back to a state of normalcy for her age. Without the prompt attention, her patient might have in a very short time, become permanently crippled even though her heart condition showed improvement. This is a classic example of the effect of a cold environment on an elderly bed patient's posture.

THE TENDENCY toward overuse of the trunk flexor muscles is often found in housewives, because the daily work around the house requires constant bending; that is, doing dishes, making beds, dusting, ironing, changing the baby's diapers, washing clothes, and other tasks. The public health nurse will quickly spot the mother in the house who habitually keeps her body bent forward as she hurries to perform her household tasks, and as a result looks very much like the "Dutch Cleanser Girl." The nurse often can help the busy mother to correct these poor postural habits by such simple suggestions as raising the height of the sink, or the table on which the baby's diapers are changed, or teaching the mother to sit when she irons, and many other practical helps.

Not long ago, an army nurse of the author's acquaintance was instrumental in helping a patient with his postwar employment plans. In a discussion one day, he mentioned that after the war he was planning on getting into the Post Office Department as a mail carrier. He had had arthritis while in the service. With considerable tact, the nurse suggested the possibility of the arthritic condition returning, because the lifting of heavy mail bags would tend to encourage the joint irritation and hasten the return of the original condition which he had succeeded in overcoming. At her suggestion he discussed the matter with his doctor and, receiving similar advice from him, decided on a more suitable occupation. This Army nurse could have given no more constructive advice than to have guided the patient away from an occupation which might have caused him to become a chronic cripple.

What inexperienced nurse in the hospital or in the home has not complied with the request of an arthritic patient for a "nice big pillow" under the knees because it felt more comfortable, only to find the hip flexor and posterior knee muscles beginning to tighten up, after keeping the hips and knees bent for a number of days and nights? Let us not be responsible for contributing to the crippling of patients in our care!

When people suffer fractures of the various bones of the body, a long convalescent period of as much as six to eight months must ensue. Nurses, either in the hospital or in the home, may have noticed that older people who suffer such serious illnesses as a fractured femur often develop a characteristic mental condition along with it. They imagine them-

selves "done for" after many months of being incapacitated, and when the time comes for actual weight bearing they are afraid and need much reassurance from the nurse and family. We might almost say the patient has a "fractured" mind, as well as a fractured limb. During these early months of convalescence, the nurse will do well to prepare the patient mentally for the day when he will start to walk again.

A city public health nurse, making a routine check on a scarlet fever case ill at home, noticed the feet of the six-months-old brother, as the mother held him on her lap for feeding. They turned up and in and the baby continued to hold them in that position, never relaxing them. On several later visits to the home to check the sick boy's throat cultures, she noticed the younger child's feet in the same characteristic position, whether the baby was lying in the crib asleep, having a feeding, or playing quietly. Realizing that this was not normal, and thinking of the possibility of a club foot condition, she discussed the condition with the family physician, notified the orthopedic nurse in the district nurse agency, and once again preventive treatment was started.

An industrial nurse in a clothing factory was quite concerned about the increasing number of complaints of backache from employees. Upon looking into the matter, she found it was the result of their lifting and carrying heavy bundles of clothing from one part of the factory to another. They were overtired at the end of the day, and many required medical care for back muscle strain. This nurse watched the men and women while at work, and suggested several simple and effective changes. A carrier system for the bundles was instituted and the bundles themselves were made up smaller. She also asked the orthopedic nurse in the local nursing agency to give a talk on postural aids and proper working positions. It was not surprising that a decline in the number of complaints of backache began to be noticed soon.

A state health department nurse was making her final round of visits to the rural schools in her area before they closed in June. She was eagerly awaited by the teachers in one of the schools who had been considerably worried about one of her fourth-grade pupils. This boy had always been active in sports, but for the past several days had been lagging during the recess play periods, had apparently lost his former "pep," and had developed a slight limp. Upon inquiring, the nurse found that the boy had had a gastro-intestinal upset and severe fatigue about ten days previously, but had recovered without a doctor's attention. At once suspicious of infantile paralysis, the nurse took him to his home, had a talk with his mother, then drove them back to their family doctor. Her suspicions were confirmed, after the doctor had made a muscle examination and diagnosed the condition as polio. Arrangements were made for the immediate admission of the boy to the nearest city orthopedic hospital for treatment. This teacher had, through the sound counsel of the public health nurse, become conscious of the importance of any deviation from normal in her pupils. Without immediate attention, this child's treatment might have been delayed several weeks, and his leg and other parts of his body might have been seriously crippled.

In conclusion, it is quite apparent that orthopedic implications in nursing are far reaching, from the nurse's subjective viewpoint relative to her own personal posture, to the objective one of prevention of needless crippling and ready recognition of orthopedic defects.

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Courtesy National Society for the Prevention of Blindness

The school nurse shares responsibility with the teacher for the eye health of the school child.

Opportunities for Teaching Eye Health

NURSES have constant opportunities for teaching sight conservation and good practices relating to the care and protection of the eyes. These opportunities occur in homes, schools, clinics, health centers, hospitals, industries, or in teaching various groups. Although methods vary with the needs of individuals and groups, much of this instruction is best given in correlation with general health teaching, thus helping people to recognize the interrelationships between the normal, healthy functioning of the eyes and general health.

Frequently such teaching is given in informal conferences in homes, schools, health centers, industries, hospitals or clinics. Often it is incidental to the rendering of nursing service. For example, when the nurse has occasion to handle a patient's glasses, she may find opportunity to give instruction about their proper care, to encourage the patient to return for an overdue eye examination, or, if she learns that the glasses have been bought over the counter without any proper examination, to guide him to proper sources for eye care. This type of teaching cannot be planned in advance; however, in many situations the nurse will, from her observations, have points in mind to discuss. She will wisely fit her instruction to the needs of the patient and will be careful to choose a time when he is likely to be receptive to it. Unless the eye problem is urgent, it may often have to await the solution of some other difficulty which seems more pressing to the patient or family. If the patient or family is not ready to give attention to an eye problem which the nurse believes so urgent that

it must be given primary consideration, she must find a way to make the urgency evident. This sometimes happens when the nurse recommends an eye examination for a school child. If the child's school work is poor, discussion of the various possible contributing factors may be the best way to convince the family that possibly the child needs eye care, and that delay may be subjecting him to an unnecessary handicap.

In the eye ward, similar opportunities often exist for teaching the patient or a member of his family to carry out prescribed treatments in the home. Another function of the nurse is to interpret to the family and to visitors the patient's need for company, for lying quiet, or for other assistance, or, conversely, for encouragement again to undertake such activities as his condition permits. For example, the visitor should understand that the patient who has both eyes covered for therapeutic reasons may need to be encouraged to accept complete inactivity. On the other hand, the patient who has lost his sight permanently may need encouragement to develop wholesome independence. Visitors may need to be warned against jarring the bed of a patient who has had an eye operation or injury. If both eyes are bandaged, visitors will probably have to be told to identify themselves as they approach the patient, to avoid confusing or startling him.

The public health nurse may contribute by preparing the patient and his family so that they will be receptive to such treatment as lying quiet, wearing glasses, or using a patch. She may also help by trying to eliminate false conceptions concerning eye treatment and by explaining why the care ordered is essential.

In the general hospital, comparable opportunities for teaching sight conservation are at hand, but frequently the nurse must stimulate interest. The nurse's attention to lighting arrangements is of particular importance to the acutely ill, and such consideration in itself has teaching value. Maternity patients are usually receptive to discussions of such subjects as an explanation of the prophylactic care of the eyes of the newborn and of the baby's visual development, care of his eyes, his first toys, and sunbaths. The mother with syphilis is likely to be interested in an explanation of need for continued treatment to protect her own and her baby's health, including sight. In the children's ward, the nurse frequently has an opportunity to suggest to parents the selection of suitable toys to bring to the children while they are in the hospital, and so to demonstrate the need for safe practices.

The questions of patients, relatives, and friends open the way for many hints on eye care and sight conservation. The outpatient department of the hospital can also be utilized to teach eye health through provision of good lighting, suitable posters and exhibits, desirable reading material and diversions for children, and by answering the questions of those who come to the clinics for help in eye problems. Demonstrations of any recommended treatment are usually more effective than is word-of-mouth instruction alone.

Awareness of the fact that surgery for the removal of cataract frequently results in good sight is of tremendous significance to a patient and his family. Personal habits of the trachoma patient, and uninterrupted treatment of the syphilitic patient, need the nurse's interpretation repeatedly. The diabetic's attention may be called to the necessity for ophthalmological care in the event of eye symptoms. The family of the glaucoma patient should have frequent reminders not only of the need for long-term ophthalmological supervision but also of the dangers to the eyes from physical and emotional tensions. should also be encouraged to arrange for eye examinations of other members of the family who are over 40 years of age, if this has not already been done.

In clinics, hospitals, health centers, schools, industries, in group teaching, interest in various aspects of eye health can be stimulated by the judicious use of such visual aids as posters, exhibits, and motion pictures. Pamphlets, too, can be used to good advantage, if carefully selected and directly related to the subject in hand. When a procedure is to be learned, demonstrations of how it is to be carried out and supervised practice are essential. This method is particularly important in teaching any type of treatment for the eyes, because of the dangers of unskillful handling of an eye.

In group teaching, participation can be further obtained by encouraging the group to develop projects and to bring in questions re-

lating to the specific aspects of eye health in which its members are most interested. For example, a group of young mothers might be interested in observing the activities of children in a nursing school and, in connection with this observation, some might pay particular attention to the visual behaviors of the children, while others might note work and play equipment and their significance in relation to vision and safety.

Where planned instruction is given, as in the Red Cross course in home hygiene and care of the sick, the eye teaching should be integrated at the various points at which it naturally fits in. Thus, in the discussion of the home environment, attention should be given to lighting and eye safety in the home; and, in teaching the care of infants, children, the sick, the convalescent and the aged, adequate consideration should be given to their eyes.

EXHIBITS AND DEMONSTRATIONS

Exhibits concerned with various aspects of sight conservation and the prevention of blindness may be planned to stimulate the interest of the general public or of a particular group. For example:

Suitable toys for children can be contrasted with unsuitable. Captions should be used to call attention to the desirability of the right type of toys in relation to ocular and general development and to their safety value.

Safety glasses of various types may be displayed with labels to indicate the type of work in which they should be used. Broken or damaged safety glasses which have prevented eye injuries in schools, workshops, or industries can also be shown with appropriate explanations. Pictures can be used to show a worker wearing the damaged safety glasses, with a caption saying how glad he is that he had them on at the time of the accident. Publications on particular aspects of eye health, suitable for popular use or for a certain group, may be displayed either alone or in conjunction with other related health subjects. For instance, a Child Health Day exhibit might include material on the care of children's eyes.

Books for various age groups may be exhibited, but in their selection consideration should be given to the size and clearness of type, kind of paper, and other factors related to the printed page which aid in comfort and efficiency of seeing. Legends should call attention to these as items to be given consideration.

Some subjects which can be presented through demonstration, include:

Arrangements for reading in bed, with due regard to posture and lighting.

Arrangement of a sickroom to provide conditions conducive to eye comfort. This should include adjustment of lighting and the provision of an eyeshade if necessary. Improvised equipment for controlling light should be utilized.

The use of a light meter and rearrangement of room to obtain the correct light for each person. This can be demonstrated in office, schoolroom, factory, or any room in which a group is meeting.

First-aid procedures in eye injuries, stressing need of absolute cleanliness (sterile equipment and solutions) and the need for ophthalmological follow up when a foreign body cannot easily be removed, or in serious injuries.

The proper placement of a baby for a sunbath, showing how to protect his eyes from direct rays of the sun.

The proper care of glasses, including putting them on and taking them off, cleansing, and putting them away safely. This should be supplemented by a discussion of correct examination, fitting, and adjustment.

PROJECTS FOR SPECIAL GROUPS

A parent-teacher association might be interested in helping develop a file showing resources for eye care, education and service to the visually handicapped, and service to the blind, including rehabilitation and vocational adjustment. Such a file can be built by finding out (1) what agencies in the state are responsible for sight conservation, care of blind children, care of adult blind and (2) what resources there are for provision of sight-saving classes, and for remedial services, including vocational guidance and training, for children and adults with limited sight. Also, a parent-teacher association might investigate the cause and extent of eye problems in their local community through obtaining from the proper local and state agencies information concerning the number of partially seeing children, the causes of blindness in children and adults, and the number of industrial eye injuries paid for under the compensation act. Such information might lead to a community project to improve the local or state situation, either through legislation or by an extension of resources. Carefully planned observation visits are very fruitful. Planning includes selecting a date and time convenient for both the group and the agency to be visited, preparing members of the group so that they know what to look for and what questions to ask, and preparing the person

or agency to give the necessary types of information to the particular group. To evaluate what has been obtained, to correct erroneous impressions, and to be most productive, such visits should be followed by a group discussion. Parents, teachers, and nurses would find much of interest in a visit to a special class for partially seeing children. They should be given an opportunity to observe the work and to discuss with the teacher the visual and educational problems of partially seeing children, the program for cooperation with regular grades, and the equipment and arrangement of the room. They will be interested to know what transportation facilities are available for children who live at a distance from the school and what arrangements are made for providing a hot lunch. In a subsequent discussion these points might be correlated with consideration of the visual screening program and the follow-up care of these children, including the arrangements for ophthalmological and general health supervision.

Where such classes are needed but are not available, community interest may be aroused through a discussion of the special adjustments necessary for visually handicapped children. An exhibit of equipment for such classes is most helpful. Some of the material used may be improvised but should conform as nearly as possible to the standard. This display should call attention to the need for ophthalmological and health supervision and for a program planned to meet individual needs.

A boy scout group might enjoy improvising equipment for visually handicapped children, such as easels, book rests, and copyholders.

A group of teachers may be interested in a study of classroom practices in relation to eye health. This might include consideration of the extent to which the schedule provides for alternating periods of near and distant visual efforts; how children are encouraged to adjust lighting to their needs; use of chalkboard facilities and visual education materials; a review of observations the teacher has made of children's behavior and appearance in relation to ocular health.

Both teachers and children like to make classroom surveys of school lighting and to experiment with making such improvements as lie within their power. A report on such a survey to the proper school authorities may result in steps for more adequate lighting where such action is needed.

A group of student nurses or a class of nurse's aides might be interested in reviewing the visual activities of convalescent children and in trying to develop some which require distant rather than near vision. In industry, the nurse will also find opportunities for working out projects with various groups. Safety campaigns are continuous in all well organized industries. Safety centers and foremen can help in developing exhibits and demonstrations of eye safety equipment and practices, and in planning motion picture programs on this and other aspects of eye care. Projects worked out by home nursing and first-aid classes can be used for display in different parts of the plant. At various group meetings the nurse can demonstrate first aid for eye injuries or, if a new vision testing procedure is to be inaugurated, this can be the subject of a demonstration and discussion.

This is Chapter X of the forthcoming manual, *Eye Health—A Teaching Handbook for Nurses,* soon to be released by the National Society for the Prevention of Blindness.

Summer Courses for Public Health Nurses

SUMMER COURSES IN UNIVERSITIES WHOSE PROGRAMS OF STUDY IN PUBLIC HEALTH NURSING HAVE BEEN APPROVED BY THE NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING

California

Berkeley. University of California. June 24-July 12. Community control of tuberculosis. Margaret S. Taylor, guest instructor. July 15-August 2. Care of the child, including measures for promotion of physical and mental health. Florence G. Blake, guest instructor.

For further information, write to Department of Nursing, 3578 Life Sciences Building, Zone 4.

Los Angeles. University of California. June 24-August 2. Family case work as related to public health nursing, principles and practice in public health nursing, administration and organization of public health nursing, public health and preventive medicine, administration of the school health program. July 15-August 2. Institute on venereal disease control. Community control of syphilis and gonorrhea. Mrs. Evangeline Morris, Simmons College, guest instructor. August 5-September 13. Public health and preventive medicine. Courses in psychology, sociology, home economics, and education will be available in both sessions.

For further information, write to Summer Session Office, 405 Hilgard Avenue, Zone 24.

District of Columbia

Washington. The Catholic University of America. July 1-August 10. Introduction to public health nursing, organization and administration in public health nursing, public health nursing in maternal and child health services, school nursing, principles and methods of teaching as applied to public health nursing, supervision in public health nursing, nutrition, orthopedic nursing.

For further information, write to Janet F. Walker, Director of Public Health Nursing, Zone 17.

Colorado

Boulder. University of Colorado. June 13-August 24. Principles of public health nursing, teaching nursing and health, advanced public hygiene, problems in public health nursing, general public health nursing field practice, nutrition, social case work for nurses, and other courses related to nursing in social and biological sciences, chemistry, psychology, and education. Supplementary basic courses in psychiatric and tuberculosis nursing for graduate nurses with deficiencies in these areas. June (date not set). Institute in tuberculosis nursing.

For further information, write to Mrs. Pearl Parvin Coulter, Associate Professor of Public Health Nursing.

Illinois

Chicago. The University of Chicago. First summer session, June 25-July 26; second summer session, July 29-August 31. Principles of public health nursing, special fields in public health nursing, public health nursing field work, the teaching of health, public health, supervision in public health nursing, organization and administration in public health nursing.

For further information, write to Nursing Education, 5733 University Avenue, Zone 37.

Indiana

Bloomington. Indiana University. June 19-August 16. Public health organization, methods of teaching in nursing, advanced principles of public health nursing, introduction to public health nursing, field work with a nonofficial public health nursing agency, field work with an official public health nursing agency, trends in nursing. Special session, August 19-September 20. Various allied courses will be offered.

For further information, write to Frances Orgain, Director in Nursing Education.

Michigan

Ann Arbor. University of Michigan. July 1-August 10. Introduction to public health nursing, special fields in public health nursing, teaching functions of the public health nurse, supervision in public health nursing. July 1-20. Venereal disease nursing. July 22-August 10. Tuberculosis nursing. Veterans may register for eight-week courses.

For further information, write to Ella E. McNeil, Professor, Public Health Nursing, School of Public Health, 109 S. Observatory.

Courses in hospital nursing service administration and personnel and nursing education are listed in the April issue of the *American Journal of Nursing*.

Detroit. Wayne University. July 1-13. Workshop: Administration of industrial nursing services in small plants. For directors of visiting nurse associations or their industrial consultants. July 15-July 27. Workshop: Integration of the social and health concepts of nursing into the basic curriculum. First summer session, June 17-July 27. School nursing, mental hygiene for nurses, community resources in social work, principles of industrial nursing, field experience in industrial nursing, field experience in visiting nursing. Second summer session, July 29-September 7. Curriculum construction in schools of nursing, ward management and teaching, field experience in ward management and teaching. June 17-September 7. Six, eight, ten, and twelve weeks courses in academic subjects required for the bachelor and Master of Science degrees in nursing.

For further information, write to Katharine Faville, Dean, College of Nursing, 5135 Cass Avenue, Zone 1.

Minnesota

Minneapolis. University of Minnesota. First summer session, June 17-July 27. Public and personal health; elements of preventive medicine; health of the school child; field work in rural nursing and family health agency; preventive medicine; public health administration and field work; environmental sanitation I; biometric principles; biostatistics laboratory; principles and problems of teaching social hygiene; supervision in public health nursing; problems in public health nursing; supervision laboratory; problems in the community health education program. A two-week intensive course on problems of administration in public health nursing will also be offered. Second summer session, July 29-August 27. Tuberculosis and its control; mental hygiene; principles of public health nursing; field work in school nursing, rural nursing, and family nursing; elementary vital statistics; preventive medicine; public health administration and field work; public health administration; topics in public health; principles and problems of teaching social hygiene. August (date not set). Workshop in industrial nursing for two weeks (graduate nurses only).

For further information, write to Ruth B. Freeman, Director, Course in Public Health Nursing, School of Public Health, Zone 14.

Missouri

St. Louis. St. Louis University. First summer session. May 14-June 22 (registration May 13). Public health nursing in venereal disease control, maternal and child health, including the health of the school child. Second summer session. June 25-August 3 (registration June 24). Academic courses.

For further information, write to Hazel Shortal, Acting Director, Division of Public Health Nursing, 1325 South Grand Boulevard, Zone 4.

New Jersey

Newark. Seton Hall College. Regular session, July 1-August 10. Postsession, August 12-August 31. Principles and techniques in teaching, principles of sociology, problems of sociology, educational psychology, child growth and development, educational and vocational guidance, fundamentals of English, voice and diction, field experience in public health nursing, principles in public health nursing, special fields in public health nursing, school nursing, nutrition and health.

For further information, write to Caroline di Donato, Director, Public Health Nursing Department, 72 Central Avenue, Zone 2.

New York

Brooklyn. St. John's University. Intersession, June 3-28. Elements of speech. Summer session, July 1-August 12. School nursing, principles and methods of teaching in nursing education, educational psychology.

For further information, write to Mary C. Mulvany, Dean, School of Nursing Education, 96 Schermerhorn Street, Zone 2.

New York. Columbia University, Teachers College. Intersession, June 5-July 2. Summer session, July 8-August 16. Directing learning activities (for students in nursing education), foundations of nursing education, evaluation and reconstruction of nursing procedures, supervision of nursing education and practice by governmental and voluntary agencies, personnel administration and counseling problems in nursing, tests and measurements in nursing education, field work in nursing, anatomy, and physiology, elementary microbiology, including bacteriology. July 8-26. Teaching in public health nursing, public health nursing. July 29-August 16. Supervision in public health nursing, school nursing, preventable diseases. In addition, courses will be offered in the academic area, foundations of education, including psychology, principles of teaching, philosophy of education, sociology, child development, personnel guidance, science, including applied chemistry, and nutrition.

For further information, write to Lillian A. Hudson, Professor, Division of Nursing Education.

New York. New York University. Intersession, June 4-28. The administration of public health. (Field work courses in public health nursing offered for four-month period beginning July 1. Applicants should notify Amy Erickson three months prior to the term for which they expect to register.) First summer session, July 2-19. Principles of public health nursing I, introduction to supervision in public health nursing. Second summer session, July 22-August 9. Principles of public health nursing II. Postsession, August 13-September 6. Industrial nursing. Courses in allied subjects will be offered in each of these sessions.
For further information, write to Mrs. Vera Fry, School of Education, Washington Square, Zone 3.

Syracuse. Syracuse University. July 1-August 10. Public health nursing, preventable diseases, the role of the nurse in public health services, nursing in schools, case work methods in public health nursing, methods of learning health. In addition, courses will be offered in education, psychology, sociology, nutrition, and health teaching. June 17-22. Institute on "The public health nurse and family relationships." Instructor, Ruth Gilbert, Supervisor of Social Work at the New Haven Psychiatric Service in the Community, and author of the book, "The Public Health Nurse and Her Patient."
For further information, write to Ruth E. TeLinde, Director, Department of Public Health Nursing, College of Medicine, Zone 10.

Ohio

Cleveland. Western Reserve University. June 17-July 26. Courses in principles of public health nursing, special fields in public health nursing, orthopsychiatry, methods of learning health in public health nursing. Courses will also be offered in the fields of English, social sciences, and education.
For further information, write to Ellen L. Buell, Director, Programs of Study in Public Health Nursing, 2063 Adelbert Road, Zone 6.

Oregon

Portland. University of Oregon Medical School. June 17-29. Workshop on integration of the social and health aspects of nursing in the basic curriculum. Mary J. Dunn, Senior Nurse Officer, U.S.P.H.S., guest instructor. August 19-31. Institute on orthopedic nursing. Lois Olmsted, Consultant for the Joint Orthopedic Nursing Advisory Service, guest instructor. June 17-August 31. Regular summer session. Public health nursing, ward administration.
For further information, write to Henrietta Doltz, Director, Department of Nursing, 3181 S.W. Marquam Hill Road, Zone 1.

Pennsylvania

Philadelphia. University of Pennsylvania. July 1-August 15 or 25. Courses in visual education, principles of case work, sociology, and history. Also general academic courses in subjects related to the professional major, as well as others specifically required for degree.
For further information, write to Katharine Tucker, Director, Department of Nursing Education, 3810 Walnut Street, Zone 4.

Pittsburgh. Duquesne University. Pre-summer session, June 10-28. P.H.N. III—Maternal and infant health programs in public health nursing. Summer Session. July 1-August 9. P.H.N. II—History and development of public health nursing, its scope, objectives, functions, and underlying principles; P.H.N. IV—School health programs in public health nursing. In addition, the general academic courses required for a degree in nursing education, with a major in public health nursing, will be offered.
For further information, write to Mary V. Adams, Acting Director, Public Health Nursing, School of Nursing Education, Zone 10.

Tennessee

Nashville. George Peabody College for Teachers. Regular summer session, June 10-August 23. Courses in principles and organization of public health nursing, maternal, infant, and preschool health; communicable diseases; school nursing; sanitation; public health administration; health and nutrition; industrial nursing; community health education; and supervision in public health nursing. A workshop is being planned to prepare teachers in Red Cross Home Nursing.
For further information, write to Division of Nursing Education, Zone 4.

Nashville. Vanderbilt University. June 3-21. A three-week Institute on Methods of Teaching Nursing Arts will be offered, with emphasis on ways and means of incorporating the social and health aspects in the program. Opportunity will be provided for observation in all clinical areas, including the rural public health field. Discussion leaders will include Jessie L. Stevenson and Lois Olmsted, consultants from JONAS. Applicants for admission should be teachers in Schools of Nursing.
For further information, write to Office of the Dean, School of Nursing, Zone 4.

PUBLIC HEALTH NURSING

Texas

San Antonio. Incarnate Word College. First term, summer session, June 4-July 16; second term, summer session, July 17-August 28. Required courses in the program of study in public health nursing, and academic courses required for the degree.

For further information, write to the Registrar, Zone 2.

Washington

Seattle. University of Washington. June 24-August 25. Courses in public health nursing and nursing education, and related fields, such as psychology, sociology, and education. Master's level courses available in teaching, administration, public health nursing and counseling. June 11-August 26—Hospital Division. Advanced clinical courses in medical, surgical, obstetric, pediatric, operating room, emergency surgery, tuberculosis, out-patient, and psychiatric nursing. Principles of administration of schools of nursing, including curriculum planning and teaching of nursing arts and sciences, will be offered to coincide with the campus dates. An intensive two-week program will be offered in maternity and infancy.

For further information, write to Mrs. Elizabeth S. Soule, Dean, School of Nursing.

Wisconsin

Milwaukee. Marquette University. First summer session, June 28-August 12—Downtown Campus. Academic courses in education, English, history, philosophy, science, sociology, speech. Second summer session, August 13-September 19—St. Joseph Hall. Principles of public health nursing I, principles of public health nursing II, maternal and child health, tuberculosis and venereal diseases. In addition, professional courses in biology and education will be offered.

For further information, write to College of Nursing, 3058 N. 51 Street, Zone 10.

VOLUNTEER HOME AIDES COMPLETE SERVICE

DURING THE 14 months of its existence, the Emergency Volunteer Home Aides of New Canaan, Connecticut—organized in December 1944 (see PUBLIC HEALTH NURSING, February 1945) and discontinued February 1946 by the Board of the VNA because of the lessening of the emergency—cared for a total of 46 cases. Because New Canaan had no severe epidemics during that period, this is a particularly creditable record.

Organized as a result of the increasing shortage of doctors, nurses, practical nurses, and household services, the aides numbered 38 women, all graduates of the Red Cross Home Nursing Course. Each volunteered her services and took a further course given by the director, Mrs. Lawrence T. Bartlett, to become acquainted with her duties and responsibilities in the homes as well as review the nursing care she was allowed to give under the rules of the organization.

The aides were sent out by the director and reported to her at the conclusion of the duty. For 22 of the 46 cases, the aides were requested by New Canaan doctors; for the remaining 24 cases, by the visiting nurses. Simple nursing care, such as bed baths, making beds, preparing and servicing diets, care of children, entertaining et cetera, was performed. "Probably their most important service," Mrs. Bartlett reports, "was their willingness to do the menial everyday household work which means so much to the peace of mind of the ill mother." The majority of patients cared for were those with grippe or flu and new mothers home from the hospital with their babies. Two to three hours daily for three or four days was the usual length of a case, although in one instance aides alternated for 14 hours a day for eight days.

The following associations participated in making the service available to the community: The Visiting Nurse Association of New Canaan, the Red Cross Nursing Activities Committee, and the Service Division of the War Council.

Reviews and Book Notes

GOVERNMENT IN PUBLIC HEALTH

By Harry S. Mustard, M.D., LL.D. 219 pp. The Commonwealth Fund, New York, 1945. $1.50.

The New York Academy of Medicine, through its Committee on Medicine and the Changing Order, invited the author to prepare this monograph as one of a series of publications.

Dr. Mustard's analysis includes the following statement: " . . . the sense of this document is to recognize political and social evolution as it relates to the public health, to view these things as nearly objectively as possible, to regret the passing of earlier concepts and manners, and to confess to a belief that a better public health will result from the changing order."

This is the accent of a book well interspersed with the author's philosophy: "The tiger no longer pounces on the unwary, but the automobile does"; "The concept that one is healthy if he is without fever and able to walk . . . " ; "fortunate that sanitary safety is to be found in the indoor toilet in a warm bathroom, rather than in the drafty outdoor privy."

The section on Federal Health Services is of exceptional interest, and its history is documented in a manner that has not been done before. The facsimile of the page of the report transmitted to Congress by Alexander Hamilton, indicating the first step in the establishment of the United States Public Health Service, has for the first time been reproduced.

More than twice as much space is given to the consideration of the federal health services as to state and local health departments combined. This may be significant of the author's belief as to the relative importance of the involved responsibilities. On the other hand, it may reflect the availability of historical data regarding the development of the Federal Health Services, which could not have been considered for state and local departments.

A section on "Activities of Government in a Public Health Program" brings together in a concise form the present status of the development in this field, and the "Summary of Trends and a Consideration of Certain Needs" indicates what may lie ahead.

Certainly, we have here set down in short space the most significant document thus far produced relating to the governments in public health.

—WILTON L. HALVERSON, M.D., *Director of Public Health, State of California Department of Health, San Francisco, Calif.*

ORAL HEALTH

By H. Shirley Dwyer, D.D.S. 132 pp. W. B. Saunders Company, Philadelphia, 1945. $1.25.

In the field of public health nursing, there has been a long standing need for a volume dealing briefly but adequately with dental health problems. As the practice of generalized nursing became more widespread, public health nurses required increasing knowledge of dental diseases. Doctor Dwyer provides a veritable storehouse of practical knowledge that should materially help the public health nurse deal with dental problems.

The first 66 pages will reward the careful reader with authentic information concerning the growth and development of face, jaws, head and teeth. Dental caries, mouth diseases, preventive and protective dentistry are likewise covered in the same five chapters.

Undoubtedly, Chapter VI, "The Public Health Nurse in a Dental Program," will appeal to those in need of concise information of such subjects as dental public health, objectives, education and treatment programs in the dental fields. One may well applaud most enthusiastically the author's "Standards for Service Clinics." Truly persuasive is his plea for preventive dental programs "to insure permanence and an optimum of healthful results," and he tells how to accomplish such ends.

The author's treatment of radio talks is one of the highlights of the volume.

The last chapter, a mere 16 pages, answers

a number of well selected questions with which nurses are frequently confronted.

Dental health programs will profit much if public health nurses, supervising nurses, and health administrators will spend an evening or two with *Oral Health.*

—J. M. WISAN, D.D.S., *Chief, Bureau of Dental Health, New Jersey State Department of Health, Trenton, New Jersey.*

WHAT TO DO ABOUT VITAMINS

By Roger J. Williams. 56 pp. University of Oklahoma Press, Norman, Oklahoma, 1945. $1.00.

This book is intended for the general person. In the preface Dr. Williams asks the question, "Are you ever bewildered by the statements about vitamins, alphabetical and nonalphabetical, that come to you incessantly over the radio and through other advertisements?" Through a unique and interesting manner, he discusses the relationship of "fuels" and "lubricants" in foods. Calories must be accompanied by the correct amount of proteins, minerals, and vitamins supplied by natural foods.

Tables, charts, and graphs of various types of food help one to diagram his intake of "fuels" and "lubricants." The title of the book has the ever appealing term, "vitamins," but here is one popular treatise which shows the need for a balance among all the nutrients.

—L. MARGARET JOHNSON, *Associate Professor of Nutrition, George Peabody College for Teachers, Nashville, Tennessee.*

AMERICAN RED CROSS FIRST AID TEXTBOOK

Prepared by the American Red Cross. 254 pp. The Blakiston Company, Philadelphia, revised edition, 1945. Cloth, $1.00; paper, $.60.

This revised edition shows many worthwhile additions which makes for improvement. There are more illustrations than the previous edition which gives a clearer view of steps in procedure. The print in the illustrations is more distinct which enables one to follow written directions more easily.

As stated in the preface, "The advance of medical science and the tremendous experience of the war prompted a complete rewriting of the book." Assistance in writing the book has been given by the Committee on Surgery of the Division of Medical Sciences of the National Research Council, and each chapter has been revised or rewritten by a physician known for his expert knowledge of the subject. For this reason, nurses will have the security in knowing the book has had medical guidance. It will be especially useful for nurses working in situations where standing orders are nonexistent and emergency care must be given.

Public health nurses will find the text valuable in practice teaching for the trial and success method. There are a few negative suggestions, but they are used effectively to emphasize the importance of correct procedure. This book contains valuable information which should be a part of every nurse's fund of knowledge which will enable her to meet emergencies.

—MAIZIE V. WETZEL, *Assistant Director, Department of Nursing Education, University of Oregon Medical School, Portland, Oregon.*

STUDENT'S GUIDE IN NURSING ARTS

By M. Esther McClain, R.N., B.S., M.S. Looseleaf. 407 pp. The C. V. Mosby Company, St. Louis, 1945. $3.00.

It has been an interesting experience to review the splendid guide book which has been prepared by Miss McClain. It shows much careful thinking in its preparation and selection of content.

Each lesson begins with a set of objectives, which is valuable to both student and instructor. The lesson outline is flexible enough to meet the overall objectives of any general hospital nursing service, and tend to set a standard which should be beneficial to the educational function and to the service rendered. The reference material is carefully chosen to assist in meeting the objectives, and needs only to be supplemented by a few articles from the wealth of material contained in professional journals and not yet incorporated into textbooks. The review questions are excellent, since they not only require factual material as answers but should stimulate discussion and further study. It is our opinion that they should not be used for testing material.

From the clinical aspect, this work should be most helpful; but from the viewpoint of the present emphasis on the integration of health and social concepts into the basic cur-

riculum, much is to be desired. This concept seems to be totally lacking in this, otherwise, excellent work.

—Olive J. Faulkner, *Associate in Public Health Nursing, Medical College of Virginia, Richmond.*

MANUAL FOR CODING CAUSES OF ILLNESS ACCORDING TO A DIAGNOSIS CODE FOR TABULATING MORBIDITY STATISTICS

U. S. Public Health Service Miscellaneous Publication No. 32. 489 pp. Superintendent of Documents, U. S. Government Printing Office, Washington 25, D.C. 1944. $1.25.

This comprehensive manual resembles the U. S. Census Bureau's "Manual of International List of Causes of Death." It is the first time that a government publication in book form has been available for morbidity statistics. A previous compilation entitled "A Standard Classified Nomenclature of Disease" was published in 1935 by the Commonwealth Fund and has been used by many hospitals.

This manual may be of interest to visiting nurse associations. A careful reading of the introduction is necessary before deciding on the possibilities of its use. The alphabetical index of morbidity terms covers 334 pages.

A number of visiting nurse associations have assisted in trying out the categories in the U. S. Public Health Service manual. In those visiting nurse associations in which the International List of Causes of Death has been used, there should be little difficulty in changing to the more useful categories in the morbidity list.

—D. E. W.

RECENT PUBLICATIONS AND CURRENT PERIODICALS

NURSING EDUCATION

New Frontiers in Psychiatric Nursing. Prepared by the Committee on Psychiatric Nursing. National League of Nursing Education, 1790 Broadway, New York 19, N. Y. 1945. 4 pp. Free.

Problems of Collegiate Schools of Nursing Offering Basic Professional Programs. Prepared by Committee on Educational Problems in Wartime. National League of Nursing Education, 1790 Broadway, New York 19, N. Y. 55 pp. Single copy: 75c.

The Public Health Nurse and the Private Physician. By C. Viola Hahn. *Virginia Medical Monthly*, July 1945, page 299. Medical Society of Virginia, Richmond, Va. Single copy: 25c.

CHILD CARE

Childhood Mortality From Accidents. Prepared by George Wolff, M.D. Publication 311. Children's Bureau, U.S. Department of Labor. Write Superintendent of Documents, U.S. Government Printing Office, Washington 25, D.C. 1945. 25 pp. Single copy: 25c.

State and Community Planning for Children and Youth. Proposals of the National Commission on Children in Wartime. Publication 312. Children's Bureau, U.S. Department of Labor, Washington 24, D.C. 1945. Free.

This publication presents suggestions as to ways in which state and local planning for children and youth may be organized and reviews briefly the experience in this field on which the suggestions are based.

SCHOOL HEALTH

Cancer Education in the School Systems. *The Field Army News*, August 1945. Pages 6 and 7. American Cancer Society, 350 5th Avenue, New York 1, N. Y. Free.

A College Program of Health and Physical Fitness Evaluation. By Charles J. Eberhardt. *Journal of Health and Physical Education*, September 1945, page 371. American Association for Health, Physical Education and Recreation, 1201 Sixteenth St., N.W., Washington 6, D.C. Single copy: 35c.

School Health Number. *Quarterly Bulletin*, July-September 1945. Wisconsin State Board of Health, 1 W. Wilson St., Madison, Wisconsin. Free
Entire issue devoted to material covering most factors in school health programs.

School Health Programs as the Students See Them. *The Journal of Health and Physical Education*, November 1945, page 489. American Association for Health, Physical Education and Recreation, 1201 Sixteenth St., N.W., Washington 6, D.C. Single copy: 35c.

NOTES FROM THE NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING

UNIFORMS AND SYMBOLS

Decision to secure a public health nursing symbol and to delve further into the matter of standardizing a public health nursing uniform was reached at the November meeting of the NOPHN Uniform and Symbol Committee in New York. This committee was appointed early in 1945 by the Board and Committee Members Section to explore the possibility of establishing both the insignia and the standard uniform for public health nurses. (See PUBLIC HEALTH NURSING, July 1945, p. 274.)

Report was made at the meeting of the opinions of a sampling of NOPHN member agencies as to whether or not they were interested in a national uniform and symbol. Of the 349 queried, 134 replied. Of these, 101 registered enthusiasm for both; 7 were not interested in a uniform but were in a symbol; 3 were interested in a uniform but not a symbol; 12 replied they were interested but said nothing more; 9 were not interested in either; 1 deferred a reply; and 1 did not believe in any kind of uniform. State directors of public health nursing in Region 2 of the U. S. Public Health Service, who discussed the subject at a meeting, were unanimous in approving both. Communications were also received from state organizations for public health nursing and state departments of health.

Suggestions made by the agencies included a preference for navy blue, advisability of designing a dress, suit, coat, and hat, and using a uniform similar to that of the Waves. Various problems involved in developing a national uniform were pointed out—climate variations, distinctions necessary for nurses in official and nonofficial agencies, for those giving bedside nursing care and those not giving it. These and other considerations led finally to the decision of the group to: (1) appoint a small committee with power to act (2) ask uniform companies and fashion designers to submit designs, and (3) plan an appropriate symbol. Since the committee met, many staffs throughout the country have discussed the subject and sent NOPHN suggestions about a possible uniform.

It is expected that the committee's recommendations will be ready in May, but a sample uniform will probably not be ready until the fall.

NEW PRICE POLICY

Because of an increasing demand for large quantities of NOPHN leaflets, it is necessary to adopt a new policy in regard to price. Leaflets now listed as free on the NOPHN Publications List will be free in quantities from 1 to 10 only. For each leaflet over 10 there will be a charge of 3 cents; for every 100 copies, $2.50; for every 1,000 copies, $18.50. Prices for leaflets not now free in any quantity will continue as before. NOPHN member agencies will receive a discount of 10 percent on all orders of 100 or more leaflets. These charges cover the cost of printing, postage, and handling, but do not cover any of the cost of preparation. This will be met by the NOPHN. Single copies of reprints of articles from PUBLIC HEALTH NURSING Magazine will still be free to NOPHN individual and agency members. All literature about orthopedic and tuberculosis nursing is free because it is financed by special grants from the National Foundation for Infantile Paralysis and the National Tuberculosis Association.

NOPHN FIELD SCHEDULE

Staff Member	*Place and Date*
Louise L. Cady	Cincinnati, O.—April 8-12
Mary C. Connor	Durham, N.C.—April 1-8 Nashville, Tenn.—April 9-20 Milwaukee, Wis.—April 21-27 Pittsburgh, Pa.—April 29-May 4
Dorothy Rusby	Houston, Tex.—April 1 San Antonio, Tex.—April 2, 3 Binghamton, N.Y.—April 22-25
Jessie L. Stevenson	Chicago, Ill.—April 16-18 Detroit, Mich.—April 19 Ottawa, Can.—April 30
Louise M. Suchomel	Wilkes Barre, Pa.—April 3-5 Philadelphia, Pa.—April 9-11 Roanoke, Va.—April 24-26
Alberta B. Wilson	California—April 1-6 Illinois—April 27

In March, after the Magazine went to press, Ruth Fisher visited Atlantic City, N.J., and Mable Grover participated in a public health survey of Evanston, Ill.

HOTEL RATES, ATLANTIC CITY, SEPTEMBER 23-27, 1946

BOARDWALK HOTELS

Hotels	Rooms with Bath		Two Rooms—Bath Between			Rooms Without Bath	
	Single	Double	2 Persons	3 Persons	4 Persons	Single	Double
Ambassador	$ 6.00- 9.00:	$ 9.00-14.00:					
Breakers	5.00- 7.00:	7.00-12.00:		$10.00-18.00:		$ 3.50- 4.00:	$ 5.00- 8.00
Brighton	7.00:	9.00-14.00:		18.00:	$21.00-22.00:		
Chelsea	4.75- 6.75:	7.00-12.00:			12.00:		
Claridge	6.00-14.00:	9.00-17.00:					
Dennis	6.00- 7.00:	9.00-14.00:		15.00:	18.00:	4.00- 5.00:	7.00-10.00
Marlborough-Blenheim	6.00-10.00:	9.00-16.00:	13.00-18.00:	17.00-24.00:		4.00- 5.00:	7.00- 8.00
Mayflower	5.00- 6.00:	7.00-12.00:		12.00-13.00:	14.00-18.00:	3.50:	5.00- 6.00
President	7.00-10.00:	9.00-15.00:					
Ritz-Carlton	6.00- 8.00:	9.00-14.00:					
Seaside	5.00-10.00:	8.00-13.00:				4.00:	6.00
Shelburne	7.00:	9.00-12.00:					
Strand*	4.50- 6.00:	9.00-12.00:		14.00-18.00:	18.00-20.00:	4.00:	8.00

Rates on Parlor Suites and DeLuxe rooms can be ascertained by direct correspondence with individual hotels.

AVENUE HOTELS

Hotels	Rooms with bath		Two Rooms—Bath Between			Rooms Without Bath	
	Single	Double	2 Persons	3 Persons	4 Persons	Single	Double
Boscobel							
Colton Manor		$ 8.00-12.00:					
Columbus		6.00:			$12.00:		$ 5.00
Crillon*		8.00-10.00:					
Eastbourne		7.50- 8.00:				$ 3.00- 3.50:	5.00- 6.00
Flanders	$ 5.00:	7.00- 9.00:			14.00-16.00:	4.00:	6.00
Fox Manor		8.00-10.00:	$12.00:	$15.00:	18.00:		6.00- 8.00
Franklin		7.00:					
Holmhurst		7.00- 8.00:			14.00:	3.00:	4.00
Jefferson	6.00:	7.00-10.00:			12.00-20.00:		4.00- 6.00
Kentucky		6.00- 7.00:	9.00:	10.00:	12.00:	3.00:	4.00- 5.00
Lafayette	5.00- 6.00:	8.00-10.00:			16.00-18.00:	4.00- 5.00:	7.00- 8.00
Madison	4.00- 6.00:	7.00-10.00:			14.00-18.00:		
Monticello		7.00:			11.00-14.00:	2.00- 3.00:	3.50- 5.00
Morton	5.00:	6.00- 8.00:			12.00:		
Penn Atlantic		7.00:				3.00- 4.00:	5.00- 6.00
Runnymede	4.00- 7.50:	6.00-10.00:				3.00- 4.50:	5.00- 7.00
Senator	4.50- 7.00:	7.00-12.00:	10.00:	15.00:	16.00-18.00		
Sterling†	4.00- 5.00	6.00- 7.00:		10.00-12.00:	12.00-14.00:	2.50- 3.00:	4.00- 5.00
Villa D'Este		10.00-14.00			16.00-18.00:	4.00- 5.00:	6.00- 9.00

*Rate includes breakfast.

†Rate subject to revision.

Note: The above rates are subject to 3 per cent municipal tax.

MAKE RESERVATIONS EARLY!

Hotel rates for the Biennial Convention of the national nursing organizations in Atlantic City, September 23-27, have been released by the Atlantic City Convention Bureau. See schedule above. The Bureau urges everyone to request reservations as soon as possible, giving complete information. Atlantic City is a haven for vacationists in September, and to assure themselves of housing facilities, conventionites should make early plans.

Provision has been made for subcommittees on housing to handle the reservations of Catholic Sisters, Deaconesses, Negro nurses, Student nurses, Men nurses, and guests. Consultants appointed for these groups are:

1946 BIENNIAL NURSING CONVENTION APPLICATION FOR HOTEL ACCOMMODATIONS

Note: Single rooms are very limited in number. Please arrange to share twin-bedded rooms.

BE SURE TO GIVE FIVE CHOICES OF HOTELS.

Consultant .....

Housing Bureau, 16 Central Pier, Atlantic City, N. J.

Please reserve the following:

Hotel..... First Choice
Hotel..... Second Choice
Hotel..... Third Choice
Hotel..... Fourth Choice
Hotel..... Fifth Choice

..... Room(s) with bath for ..... person(s). Rate $..... to $..... per room.
..... Room(s) without bath for ..... person(s). Rate $..... to $..... per room.
..... Suite(s) 2 rooms-bath between for ..... persons Rate $..... to $..... per room.

Arriving Atlantic City, September ....., 1946, hour a. m. p. m. Leaving September ....., 1946.

Note: *You will receive confirmation direct from the hotel accepting the reservation. Please bring confirmation with you.*

Room will be occupied by: Mr. .....
Mrs..... Address City (zone) State
Miss..... Name

PLEASE PRINT PLAINLY Mr.
Mrs.....
Miss..... Name Address City (zone) State

Note: Please attach list of additional names if necessary . . . . . Give complete information . . . . . REFER TO CONSULTANT LIST BELOW. . . .HOTEL RATE LIST PAGE 201. . . . FILL IN AND MAIL NOW!

Catholic Sisters—Isabel Hutchinson
Deaconesses—Lulu Suddoth
Negro Nurses—Mrs. Viola S. Murray
Student Nurses—Isabel Hutchinson
Men Nurses—George Berube
Guests—Isabel Hutchinson

All others should address their reservations to A. H. Skean. The registration blank on this page may be clipped and used for reservation purposes. If a letter is sent instead, be sure that complete information is included and that the proper consultant is specified.

Railroad representatives have indicated that there will be no special convention rates this year, and the Transportation Committee advises that reservations for the round trip should be secured well in advance. The Office of Defense Transportation has lifted its restriction requiring reservations to be made 14 days prior to travel date.

Watch your next issue of PUBLIC HEALTH NURSING for more convention news.

RETIREMENT PLAN GROWS

Sixty-two visiting nursing associations have enrolled to date in the National Health and Welfare Retirement Association Plan, and the number is growing week by week. Connecticut leads all other states, with 8 associations enrolled in the Plan; Ohio and Massachusetts follow with 7 and 6 respectively. The lineup of the other states with agencies enrolled is as follows: Alabama—1, Arkansas—1, California—2, Delaware—1, District of Columbia—1, Illinois—3, Indiana—4, Iowa—1, Michigan—3, Minnesota—2, Missouri—1, New Jersey—3, New York—4, Oklahoma—1, Pennsylvania—5, Rhode Island—4, Virginia—2, Washington—1, Wisconsin—1.

The Association has recently announced two further developments toward increased benefits of the Plan: (1) The Executive Committee has recommended to the Trustees the amending of the By-Laws to provide that "a participant may, upon terminating his employment at any time before retirement age, receive back his own contributions in cash plus interest." Contributions left in the Plan, however, would always be matched by those of the employer for retirement purposes or as a death benefit. (2) On the basis of further studies benefits are expected to be about 10 percent greater than originally anticipated. This is due to the fact that a "lower average cost for insurance and expense is now felt justified for most employees" and "dividends and other

(Continued on page 204)

Cast of the visiting nurse radio dramatization, "No Place Like It," discuss script with Edith Wensley, assistant director, NOPHN. From left to right: Robert Lewis Shayon, director-producer, Shirley Booth, Patsy O'Shea, Jimmy Lipton, Mrs. Wensley, Josephine Hull, of "Arsenic and Old Lace" and "Harvey" fame, and John Gibson, narrator of the Community Chests and Council series.

Public Information Tips

NOW THAT Know Your Public Health Nurse Week is over, millions of people in this country should have a better idea of the public health nurse's place in helping to protect the health of family and community. But the job of interpretation should continue all the year-round. Response to the "Week" was overwhelming—so overwhelming, in fact, that the NOPHN stockroom was completely drained of publicity kits, leaflets, and posters several weeks before the "Week" began. In the halcyon days last November and December, when we were trying to plan what material to prepare and in what quantity, we decided we would need double what we had ordered for Public Health Nursing Day in January 1945. And we wondered if we had been extravagant because, after all, the Board and Committee Members Section (which sponsored the "Week") had no budget from the NOPHN—only what it was able to raise on its own initiative. Then in January, information about the "Week" went to all individual and agency members. Orders soon began to come in from communities with well organized plans for observing the "Week." It looked as though we would be left with a large surplus of everything. But we didn't reckon with that factor that throws the best-laid plans into chaos—last minute orders. Toward the end of March an avalanche of orders, all "rush," hit the NOPHN. Everything was gone in no time. If these orders had been received earlier, it would have been possible to have restocked. We are sorry if you were one of the communities who was disappointed. We hope you will understand—and help us plan now for the 1947 "Week." A questionnaire will go soon to all communities who wrote they were observing the "Week." In this we shall outline the materials we hope to produce next year, what they will cost, and ask you to estimate how many of each your agency or community will use. This is the only way we can plan for 1947 and feel safe in spending large sums for quantities of material. Highlights of how the "Week" was observed in many areas will be featured in an article to appear later in the Magazine.

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One of the most popular leaflets ever prepared by NOPHN proved to be "Know Your Public Health Nurse." The fact that it was free (except for postage

and handling charges) undoubtedly influenced its popularity, we admit. Be that as it may, NOPHN could not begin to meet the demand. A new supply is being printed by courtesy of the Metropolitan Life Insurance Company and will be ready in May. To make sure that there is a fair distribution, all orders must be limited to no more than 500. Handling and postage charges for that quantity will be 65 cents east of the Mississippi and $1.10 west of the Mississippi.

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The series of recordings of dramatizations for radio produced by Community Chests and Councils, Inc., has become an annual event of note. This year's series, now ready for distribution, includes a visiting nurse dramatization, "No Place Like It." It's the story of a homesick veteran who is sent home from the hospital on a special furlough while waiting for an artificial leg. Mother love almost proves his ruin, but the combined efforts of his family physician, a visiting nurse, and an accident save his manhood and his health, and start him on the road to independence and a new life.

The author of the script, Eloise Walton of the public relations staff of Community Chests and Councils, Inc., deserves a generous corsage of orchids for the excellent piece of work she has done. Recognizing that national organizations are deeply concerned about the interpretation of local agencies in their fields, she consulted with NOPHN from the very start about story ideas and technical information. NOPHN in turn made sure that the proper experts checked specialized information. In the process, care was taken that none of the dramatic values would be lost.

The recording, "No Place Like It," is available only if ordered as part of the entire series. Visiting nurse associations, however, may secure it by asking their community chests for the copy once it has been aired over a local radio station. The recording can be played at community gatherings and be an invaluable aid in interpreting visiting nurse service.

. . . .

Congratulations to the California State Organization for Public Health Nursing on their excellent Bulletin which made its debut in February. It's well written, newsy and interesting, not only to nurses but to other people as well. We particularly like the statement in connection with Know Your Public Health Nurse Week: "Here is a chance to call on the leadership of your citizens. Public health nursing is their service. Citizens should comprise the backbone of local committees." But we wonder if this forthright statement is not nullified later in the Bulletin by the admonition, "Use your citizens effectively in your program." Citizens who are not nurses will gladly cooperate in a partnership but don't like to be "used." It's merely a matter of terms, but important. Public health nursing groups throughout the country are apt to use the term frequently. Let's abandon the practice of "using" anybody.

. . . .

The Visiting Nurse Society of Philadelphia celebrated its sixtieth anniversary March 5 with a special dinner. To mark the occasion a special booklet, measuring 3½ by 4½ inches, was prepared, setting forth the Society's history. The leaflet's effectiveness is heightened by frequent quotations from original reports made by the founders. Contrast and emphasis are provided by printing selected sentences in red instead of by using headlines. The future receives its share of attention in a statement from Ruth Hubbard, general director: "The Society looks backward but only for a moment, since it cannot and would not overcome the habit of a lifetime of looking forward." Copies are included in the NOPHN loan folders on printed material which may be borrowed by NOPHN individual and agency members.

E.W.

Retirement Plan

(Continued from page 202)

credits are expected and will be used to increase the benefits of participants."

The first death claim for a visiting nurse was received in February. A staff member of a Pennsylvania agency, 60 years of age, died four months after joining the Plan, and because of the death benefit provision in the Plan her beneficiary will receive 10 months' salary. This provision is of great interest to older workers who realize they are starting too late to build up a substantial annuity and are glad to have 10 months' salary as a death benefit at no cost to them.

NEWS AND VIEWS

On National Nursing

NATIONAL NURSING COUNCIL NEWS

The National Nursing Council completed its choice of officers and directors for 1946 at an annual meeting held March 1 at the Hotel Pennsylvania, New York City. New chairman is Sophie C. Nelson, director, Visiting Nurse Service, John Hancock Mutual Life Insurance Company, Boston. She succeeds Stella Goostray, superintendent of nurses and principal of the School of Nursing, Children's Hospital, Boston, who served as Council chairman during the past three and one-half years. Miss Nelson is a former president of the NOPHN, has long been active in national nursing affairs.

Other officers elected by the National Nursing Council are vice chairman, Anna D. Wolf, director, School of Nursing, The Johns Hopkins Hospital, Baltimore; secretary, Pearl McIver, chief, Office of Public Health Nursing, U. S. Public Health Service; treasurer, Henry B. Stimson, investment counselor, of New York City; assistant treasurer, Marian G. Randall, executive director, Visiting Nurse Service of New York.

Directors chosen were: Katharine J. Densford, dean, School of Nursing, University of Minnesota; Miss Goostray; James A. Hamilton of James A. Hamilton and Associates, hospital consultants; Lucile Petry, chief, Division of Nursing, U.S. Public Health Service; Marion W. Sheahan, director, Division of Public Health Nursing, New York State Department of Health; Ruth Sleeper, assistant principal, School of Nursing, Massachusetts General Hospital; Mrs. Mabel K. Staupers, executive secretary, National Association of Colored Graduate Nurses.

A new organization member of the Nursing Council is the American Association of Industrial Nurses. Organized three years ago, its present membership is 3,000.

New members-at-large in the Council Corporation include Mrs. Langdon P. Marvin, chairman since its organization in 1942 of the New York City Nursing Council for War Service and past chairman of the English Speaking Union, and Edward Lewis, executive secretary of the Greater New York Urban League. While chairman of the Baltimore Urban League, Mr. Lewis spearheaded a campaign that led to the appointment of nineteen Negro graduate nurses to the staff of Baltimore City Hospital, and acceptance of nineteen Negro nurse's aides by the same institution.

Mrs. C.-E. A. Winslow of New Haven, Connecticut, has become a representative of the National Organization for Public Health Nursing on the Council Corporation. Wife of Dr. C.-E. A. Winslow, who is professor emeritus of the Yale University Department of Public Health and editor of the *American Journal of Public Health*, Mrs. Winslow has long been active in behalf of public health.

Goal of the new National Nurse Recruitment Committee organized by the Council is the enrollment of 40,000 new students in schools of nursing, July 1, 1946 to July 1, 1947. This figure is above the 38,113 admitted in 1940 but 25,000 below the wartime peak of 65,521 admissions during the school year of 1943-44.

Foreseeing that requests from other countries for the education of nurses here, and varied services in the nursing field, will increase as the UNO health organization becomes active, the National Nursing Council is forming a "committee of interests" on international nursing.

The nucleus of this new committee met early in March to prepare a proposed program to be discussed at the meeting of the Council's National Nursing Planning Committee, called for April 3 and 4 in New York City.

Among those who have already accepted membership on the committee are Virginia M. Dunbar, dean of the School of Nursing and director of the Nursing Service, Cornell University-New York Hospital, until recently director of the Nursing Service of the American Red Cross, and Ruth Taylor, director of the Nursing Unit, Children's Bureau, U.S. Department of Labor.

Miss Dunbar and Miss Taylor made preliminary inquiries at the request of the Planning Committee, which included conferences with representatives of the Division of Cultural Cooperation, Department of State, and the newly established Office of International Health Relations, U.S. Public Health Service.

The inquiry indicated a lively appreciation on the part of officials of the importance of nursing in the whole program of international cooperation, and a keen interest in meeting needs wisely. At present,

the Department of Cultural Cooperation, Department of State, provides for Inter-American programs only, but legislation is now pending in Congress to extend this cooperation to other countries as well.

Ways must be opened, the National Nursing Council believes, for more young women from countries where health services are not developed to the extent that they are in the United States to come here for a complete nursing education, and for nurses with some preparation to gain additional experience. Furthermore, schools will need to be encouraged to accept students from foreign lands.

Another "committee of interests" will be set up to review federal legislation which affects nursing. It will include representation from Council member organizations interested in legislative problems. It will concentrate upon seeking information about plans for legislation when they are in their earliest and most formative stages and will leave to Council member organizations all efforts to influence the course of legislation once bills have been introduced in Congress.

As a guide to thinking on one type of potential future legislation the Council has agreed upon a statement of basic policy in regard to federal aid to nursing education.

ELLA BEST SUCCEEDS MRS. SCOTT

Mrs. Alma H. Scott, whose resignation as executive secretary of the American Nurses' Association was recently announced, was succeeded March 1 by Ella G. Best, associate executive secretary of the Association since 1935. Miss Best came to the ANA headquarters staff in 1930 as field secretary. From 1926 to 1930 she was assistant to the dean at Cook County School of Nursing, Chicago. Prior to that she was on the faculties of St. Luke's and Michael Reese in Chicago and Miami Valley in Dayton, Ohio. She studied at the University of Chicago and at Teachers College, Columbia University. Mrs. Scott came to the ANA staff as field secretary in 1929. She became assistant director the following year, acting director in 1933, and director in 1935. She was an Army nurse during the first World War, studied at Teachers College, Columbia University, and was executive secretary of the Indiana State Nurses Association and educational director for the Indiana State Board before she came to the ANA. The membership of the ANA in 1929 was 78,560; at the time of Mrs. Scott's departure, over 180,000.

FELLOWSHIP IN HEALTH EDUCATION, 1946

Fellowships for one year of graduate study in health education, leading to a master's degree in public health, are offered for the academic year starting in the Fall of 1946 to qualified men and women by the U.S. Public Health Service through funds made available by the National Foundation for Infantile Paralysis. The training consists of a year's study in public health education in an accredited school of public health, including an academic year of eight or nine months and three months of supervised field experience in community health education. A stipend of $100 a month for the entire period, tuition, and travel expenses for field experience are allowed.

Applicants for the fellowship must be in sound health, between the ages of 22 and 40, citizens of the United States, and meet the requirements of the School of Public Health of their choice. In addition to a bachelor's degree from a recognized college or university, courses in the biological and/or physical sciences, sociology, and education may be required. Application forms may be obtained from the Surgeon General, U.S. Public Health Service, Washington 25, D.C. Completed forms, accompanied by two recent photographs, and official transcript of college credits, and a 500-word statement of why applicant is interested in entering the field of health education, must be in the hands of the Surgeon General by June 1, 1946. Only complete applications will be considered.

COUNSELORS' HANDBOOK

A Handbook of Information for Nurse Veterans recently published by the American Nurses' Association summarizes data about privileges, benefits, and services which are provided for the veteran through their professional nursing organization, and state and federal laws and suggests how they can be made available. As stated in the Foreword by ANA President Katharine Densford, it is designed to help the veteran nurse pick up the threads of civilian life and "weave them into a pattern which will result in success and happiness."

Prepared especially for the use of nurse counselors by the ANA Professional Counseling and Placement Service, Inc., with the cooperation of the Nursing Information Bureau, the booklet includes instructions about important papers, claims and benefits, information about education, vocational rehabilitation, and civilian nursing opportunities, and a list of organizations at the service of the nurse veteran. A limited number of this "counselors' edition" has been published and made available to state nurses' associations. Another edition for general use may be issued at a later date.

HEADS OF NEGRO HOSPITALS MEET

The National Nursing Council, in cooperation with the National Conference of Hospital Administrators, recently held a two-day meeting in Philadelphia, which brought together approximately 150 hospital

administrators and nursing directors in Negro institutions from all parts of the country. The well attended sessions provided an opportunity for the discussion of many problems which confront administrators in Negro hospitals. The conference was the first to be held since the start of World War II. Principal speakers discussed the role of the nurse in planning for national needs, problems of budgeting the nursing school, securing and stabilizing faculties, readjustment to peacetime, public relations, the practical nurse, and many others. Lively discussion followed the main presentations.

From Far and Near

● The list of programs of study for the preparation of public health nurses approved by the NOPHN, which was omitted from Bulletin 1944, No. 3, "Accredited Higher Institutions," published by the U. S. Office of Education, appears in their semi-monthly publication, "Higher Education," Vol. II, No. 5, November 1, 1945, on pages 8 and 9.

● With reference to her appeal for supplies for nurses in Europe (see PUBLIC HEALTH NURSING, February, p. 55), Elizabeth Tennant announces that it is now possible to send packages to Poland direct rather than through the State Department, Foreign Mailing Room. Packages of 11 pounds are acceptable. If soap is included in the parcels, five pounds of toilet soap and ten pounds of laundry soap are permissible except for the United Kingdom which permits only two pounds of either kind of soap. These restrictions are made by the Department of Commerce rather than by the Post Office Department.

● Announcement is made by the Minnesota State Board of Examiners of Nurses that, as of July 1, 1945, all Minnesota registered nurses must renew their registrations annually if they wish to maintain their status as Minnesota registered nurses. Nurses who have not received application forms should notify the Minnesota Board of Examiners of Nurses, 222 Minnesota Building, St. Paul 1, Minnesota at once. These forms must be returned and accompanied by the $1 renewal fee if applicant wishes to renew the registration. No fee is required for nurses wishing to be placed on the non-practicing list or for nurses serving or having served with the armed forces for the duration of the war and one year thereafter, but the forms must be returned in any case.

● Published jointly for the NOPHN and 30 other cooperating organizations by the National Safety Council and the American Red Cross, the 16-page booklet "A Man's Castle; A National Program for the Prevention of Home Accidents" is just off the press. Attractively illustrated, it presents a practical program for reducing home accidents and shows how the cooperating organizations can help. This is a program which "must be agreed upon and put into action by all those concerned." As a member of the National Conference on Home Safety, NOPHN urges close cooperation with this program on the part of all public health nurses. This booklet is being sent free to all members of the NOPHN. Additional copies may be secured from the National Safety Council, 20 N. Wacker Drive, Chicago 6, Ill., and from the American Red Cross, Washington, D.C.

● The annual conference of the National Association for Practical Nurse Education will be held May 20-21 at the Visiting Nurse Service of New York, New York City. Proposed revisions of the bylaws will be presented to the membership.

● A rheumatic fever exhibit will be on display at the meeting of the New York State Medical Society the week of April 29 at the Pennsylvania Hotel in New York. Public health nurses in the city at that time are invited to inspect the exhibit, especially on April 29 or 30.

● With the theme, "Building for Tomorrow with the Youth of Today," National Boys and Girls Week marks its 26th annual observance this year from April 27 to May 4. The program is designed to focus the attention of the public on the problems, interests, and recreations of youth, and on the part played by the home, school, and youth-serving organizations in the development of character and good citizenship in growing boys and girls. Child Health Day, coming as it does within that week, is suggested as the program for May 1. Suggestions for observing the week, including a poster and a manual, may be obtained free of charge from the National Boys and Girls Week Committee, 35 East Wacker Drive, Chicago 1, Illinois.

Reporting Blindness—All cases of legal blindness in New York State must be reported to the Commission for the Blind of the State Department of Social Welfare in accordance with a recent amendment to the act creating the New York State Commission for the Blind. It is now the duty of every health and social agency, attending or consulting physician or nurse to report to the State Commission for the Blind, in writing, the name, age and residence of persons who are blind within the definition of blindness and to furnish other needed information.

This data will further the state's effort to prevent blindness through a comprehensive knowledge of the facts relative to the causes of blindness. It will also aid in the earlier recognition and detection of cases where remedial measures for restoration of vision are still possible. Likewise, those who may desire the services of the Commission for the Blind will be benefited through acquaintance with the opportunities available to which they are entitled.

Legal blindness is defined as total blindness or impaired vision of not more than 20/200 visual acuity in the better eye and for whom a diagnosis and medical findings show that vision cannot be improved to better than 20/200; or who has loss of vision due wholly or in part to impairment of field vision or to other factors which affect the usefulness of vision to a like degree.

Apparent blindness should also be reported even though not based on an eye examination.

Toothbrush Design—Recently crystallized professional opinion recognizes the advantages of compactness and simplicity of design by favoring relatively small narrow head, straight-trim brushes, according to H. Berton McCauley, D.D.S., in a statement authorized by the Council on Dental Therapeutics appearing in *Journal of the American Dental Association,* March 1946. These conform closely to functional requirements.

Toothbrushes as they are known today, states Dr. McCauley, probably came into being two or three hundred years ago. The earliest known record of use was in China about 1600. They developed into numerous patterns many of which are extremely inefficient and even harmful as universal instruments. Some defects mentioned are arching and excessive tapering, too close spacing of bristles, uneven length of tufts, too large head both in width and length of tuft rows. Dentists also definitely disfavor motor-driven and novel tooth-cleaning devices.

Since 1938, hog bristles have been replaced by synthetic bristling filaments of nylon which are more durable and elastic though their relative merit as cleaning agents has not been determined. Modern plastics have been found satisfactory for handles which, to be satisfactory, should provide a comfortable grasp, be reasonably rigid, smoothly finished, strong, and relatively straight.

Hearing of Very Young Children—To test the hearing of very young children, Edmund P. Fowler, M.D., suggests the following methods approved by the American Society for the Hard of Hearing:

1. If the baby is able to repeat spoken words or respond by turning and looking at the speaker, test with the faintest whisper at 4 feet or the loud whisper at 20 feet from the child. It is best to stand out of sight so that the child does not sense any movement to attract its attention. If the words are not heard by the child at these distances as indicated by failure to respond properly, it means a loss of over 20 decibels which, in Dr. Fowler's opinion, should be the standard set up for otological examination and follow-up for little children.

2. If the baby knows only three or four words, this is sufficient because, by varying the sequence, it is possible to tell whether or not they are really heard or only guessed. If a baby over two years of age does not know a few words, this alone would indicate some defect and the necessity for a careful examination. It aids and interests subsequent patients to allow 3 or 4 children in the offing, so that they may see the testing procedure. Do not allow the one being tested to see them.

3. For little babies, one satisfactory method is, while attracting attention with the manipulation of some trinkets or a picture, have someone behind them, without making any motion, say in an ordinary whisper "baby," "mama," "daddy," "bottle," or some word with which the baby seems most familiar, either by hearing or by reading the lips. If the baby hears a whisper (it being a sound with which he is familiar), he will almost invariably turn around. If he does this when the faintest whisper is used at 4 feet and the loud whisper at 20 feet, it is probable that his hearing is not down more than 20 decibels. If he hears the whisper coming from greater distances than these, it is certainly near normal. The child must feel no breath or feel and see no movement of the tester.

Prevention of Cancer of the Cervix—Prevention of cervicitis and prevention of cancer by adequate treatment of existing cervicitis as well as early diagnosis by periodic examination of women of 25 years of age and over offer the best solution to cancer of the cervix. This is a major conclusion of the report of a second survey of 10,000 cases of deep cauterization of the cervix by Dr. B. Z. Cashman in the *American Journal of Obstetrics and Gynecology,* February 1945.

In the original survey, report of which was published in 1941, 10,000 cases of deep cauterization of the cervix in the Elizabeth Steel Magee and St. Francis Hospitals, Pittsburgh, were studied over a period of 25 years, ending in 1939. In the follow-up study, 3,143 replies to a questionnaire were received. In the latter, the average time interval after cauterization was 8.7 years, and the average age of the patient 42.8 years. Results showed approximately 80 to 85 percent reduction in the incidence of cancer, or in deaths from cancer of the cervix in the group followed up. Expected incidence was 14 to 23 cases of cancer of the cervix in the time observed. Two cases are known to have occurred before the survey, and one of them died from cancer of the cervix, when 11.6 deaths would be expected.

Other conclusions reported are (1) chronic cervicitis seems to be a contributing factor in the cause of carcinoma of the cervix (2) deep cauterization is often necessary to destroy infection in the cervix (3)

after deep cauterization, when the uterus is not removed, careful postoperative care and treatments are necessary. Only two cases of cancer of the cervix are known to have occurred in the series of 10,000 studied.

Penicillin Therapy on the Uterus—Because of reports that both abortions and menstrual bleeding have been associated with penicillin therapy of the uterus, the records of 156 prenatal patients treated with penicillin have been reviewed at the Rapid Treatment Center at Bellevue Hospital, New York. (Speiser and Thomas, *Journal of Venereal Disease Information*, January 1946.) The patients studied had received penicillin in amounts varying from 600,000 to 2,400,000 Oxford units. There were 5 cases who showed some aberration from the usual course, but in none could a relationship between penicillin therapy and the alteration in the course of pregnancy be suspected. Of three who delivered during the course of penicillin therapy, in only one instance was there any question regarding the possible effects of the treatment upon the pregnant uterus, and it was even considered doubtful. Episodes of uterine bleeding occurring in nonpregnant women while under penicillin therapy were also investigated. The records showed that penicillin was administered to over 1,300 women without any menstrual abnormality attributable to the effects of such therapy being noted. Of 100 patients under treatment for early syphilis, observed following the report of the unusual effect of the penicillin therapy, only one case showed any alteration from the usual cycle. These studies led the authors to the following conclusion: "As there could be no question as to the reliability of the published reports, perhaps some associated pathologic process may have accounted for such episodes of intermenstrual bleeding, namely, an associated cervical erosion, endometritis, salpingitis, ovarian cysts, or uterine neoplasms."

Need for Home Gardens in 1946—President Truman urges the Nation's home gardeners to continue this year their efforts which added so much to the national food supply during the war. Commenting on the present plans of the Department of Agriculture to stimulate a broad program of gardening this year, the President said:

"During the war period, gardening further demonstrated its value to our people in many ways. The splendid response to the appeal for more home-produced food was an important factor in making it possible during the war for the people of this country to be better fed than before the war while supplying the best-fed fighting forces in the world and providing essential food supplies to our allies. The threat of starvation in many parts of the world and the urgent need for food from this country emphasize the importance of continued effort to add to our total food supply this year.

"A continuing program of gardening will be of great benefit to our people. In addition to the contribution gardens make to better nutrition, their value in providing outdoor physical exercise, recreation and relaxation from the strain of modern life is widely recognized. The Department of Agriculture through a long-time garden program can do much to encourage more attractive home surroundings and improved community development, and can provide a large body of citizens with much needed assistance in home gardening."

The March 1946 *Michigan Public Health* is devoted entirely to gardening and has many excellent suggestions on what seeds and plants to buy.

Infant Mortality Decline During War—Despite many adverse conditions such as crowded housing, disrupted family life, and depleted medical and nursing personnel, and at a time when the birth rate rose sharply, infant mortality reached a record low in the United States during the war years. This improvement is credited in the *MLI Statistical Bulletin*, December 1945, to recent advances in medicine, particularly sulfa drugs, increased hospitalization of births, the EMIC program, and the generally higher standard of living for a large proportion of the population. In the white population, deaths among infants under 1 year dropped from 43.2 per 1,000 live births in 1940, to 37.5 per 1,000 in 1943—a decline of 13 percent. Among the colored population, the decline was 15 percent. Significantly, the greatest relative improvement took place in those geographical areas where the infant mortality was highest, and for white babies the decrease was relatively twice as rapid in small towns and rural areas as in the larger cities. Largest decrease in mortality among white infants was recorded for pneumonia and influenza, reflecting the use of chemotherapy in the treatment of pneumonia. The mortality from premature birth, the outstanding cause of infant death, was reduced by more than 13 percent between 1940 and 1943 among both white and colored babies. This is credited mainly to better prenatal care of mothers and to the increased proportion of deliveries in hospitals. Better obstetrical service, according to the *MLI Bulletin*, accounts for the substantial decrease in the death toll from injuries at birth. A marked decline in mortality from diarrheal disease probably resulted from greater nutritional knowledge on the part of mothers and their improved food-purchasing status.

Cancer Nursing—Incorporation of bedside care for cancer patients in the generalized nursing program of the Nassau County Department of Health, Mineola, New York, has been effective in providing skilled nursing care to cancer patients, it is reported in *Health News*, December 17, 1945. The Nassau County Department was the first local health department in the state to include such care in its generalized program and also the first to utilize cancer reporting as an administrative tool for this pur-

pose. (*See also* "Cancer in a Public Health Nursing Program," PUBLIC HEALTH NURSING, August 1941, p. 474.)

With the inclusion of the cancer service within the Division of Public Health Nursing, an educational program was arranged on a threefold basis: (1) to teach cancer prevention and urge prompt medical care when indicated (2) to interpret instructions to patients for the clinic and private physician and teach them to care for themselves or demonstrate and supervise care given by other persons (3) to give nursing care when necessary.

After cancer became reportable, the Department adopted the practice of inquiring of the physician in each case whether nursing care was desired, which served the dual purpose of reminding the physician of the service and providing nursing care as it was desired. As more public health nurses are available, this aspect of the program is expected to expand.

From 1940 to 1944 patients referred for nursing care varied in the following ratios: 1940, 1 out of 14 was referred; 1941, 1 out of 4; 1943, 1 out of 6; and in 1944, 1 out of 8. Of the total 624 cases referred during the five-year period, 541 were referred by a hospital, 47 by private physicians, 36 by agencies or individuals. There were 379 malignant cases, 245 benign. A total of 6,097 visits was made to all cases, 2,098 of which were made to encourage return clinic treatment or examination. "If this relatively high proportion of follow-up visits were reduced, more service would be available to other patients," the article in *Health News* states.

"In 63 instances, patients were taught to care for themselves and in 162 others some person was taught and supervised in giving the required care. The greatest number of visits in relation to the number of months of care was 1,368 cases under supervision from one to two years. A small fraction, one-fourteenth, were for the purpose of giving terminal care. Visits totaling 787 were made to those under care from one to three months. More than half of these were for terminal care.

"The highest number of visits to a single patient was 160, over a period of 20 months, to a woman with cancer of the rectum. Over a period of 12 months, 144 visits were made to give bedside care to a victim of cancer of the sigmoid and to supervise services rendered to the patient by a member of the household. The greatest number of cases referred in any one year was 204 in 1941 and the lowest, 86 in 1942. There were 114 cases referred in 1944."

Orthoptics, What It Is—Dealing with defective habits of seeing, defects of binocular vision, and defects of ocular motility, orthoptics is the art of teaching patients, child or adult, the proper use of the eyes. It is not a system of diagnosis. Much which passes for orthoptics, however, is far from the real thing, according to an article on the subject by Dr. W. B. Lancaster, adopted by the Council on Physical Medicine of the AMA and published in the *Journal of the AMA*, February 16, 1946. There is no legal restriction limiting the practice of orthoptics, and it is carried on mostly by optometrists, nurses, office assistants, and doctors, and often by the use of some automatic machine or apparatus which they are taught to use by the manufacturer's traveling representative. Most such operators have only hazy or erroneous conceptions of what is wrong and what is needed to correct it. On the other hand, in the hands of the few who are masters of the best techniques certain apparatus such as a major amblyscope, a stereoscope, prisms and various small accessories, are indispensable.

The defects of binocular vision or of ocular motility are divided into (1) heterotropia and (2) heterophoria. Heterotropia is an obvious or manifest deviation of the eye from the visual axis and is also called cross-eye or strabismus. Heterophoria is a constant tendency of the eye to deviate from the normal counterbalance by simultaneous fixation forced by muscular effort (prompted by the desire for single binocular vision). Deviation is not apparent, hence is said to be latent.

At birth, the eyes, including the neuronic pathways involved in vision, are imperfectly developed. Their subsequent growth, anatomically as well as physiologically, depends somewhat upon usage. Obstacles may turn the course of development into wrong channels, and it is then that the skillful and understanding guidance of the orthoptic technician is needed to assist the patient in the acquisition of more normal and useful habits or reflexes. The aim of the orthoptic technician is not the strengthening of some muscle or muscles alleged to be weak but is rather to teach the patient better control and coordination, better reflex response to his environment. Therefore, it is important for the technician to have an understanding of the physiology of vision and the psychology of teaching and of learning.

A surprising number of patients for whom glasses had been considered indispensable by someone not well informed in orthoptics can be taught to use their eyes without glasses. Glasses may, of course, help greatly or be indispensable in some cases. Operations often save time and make some cases amenable to orthoptics that would be hopeless otherwise. Refraction, orthoptics, and surgery are a powerful team which should work together.

Orthoptic skills vary among operators, and the author suggests that the more skillful technicians should be allowed to spread the knowledge of their methods by advanced or graduate teaching. There is need, he concludes, for graduate individual instruction in orthoptics.

A Council on Orthoptics has been organized in the United States which exercises general supervision over orthoptics. In particular it issues certificates to orthoptic technicians who apply and are found competent and who comply with the regulations of the council.

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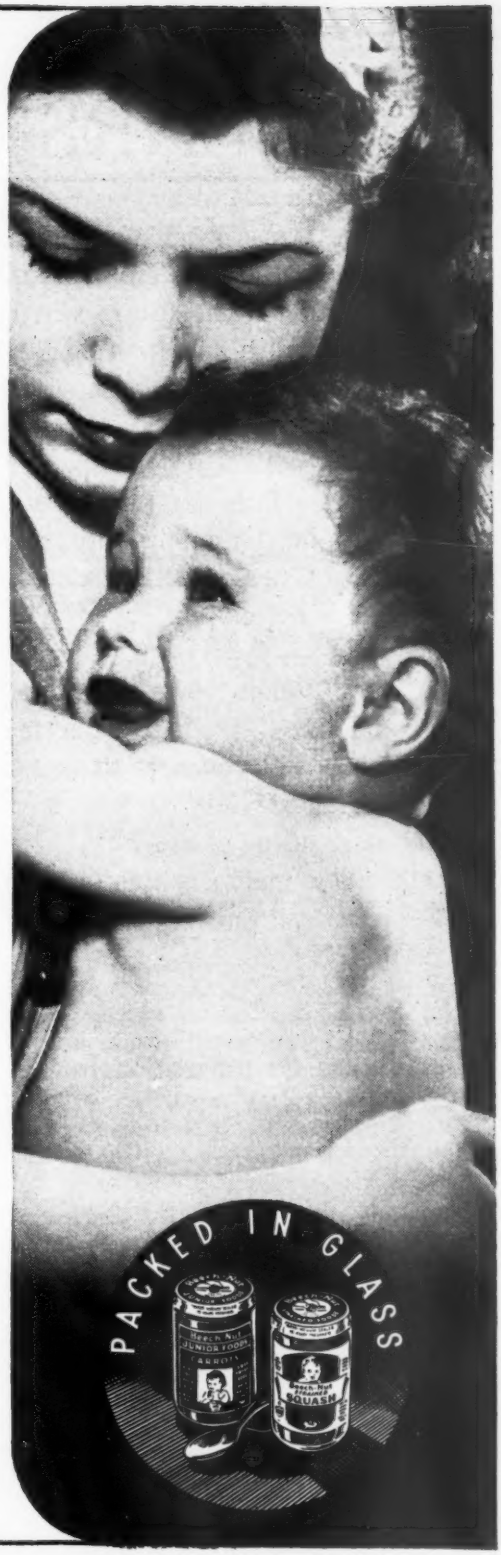

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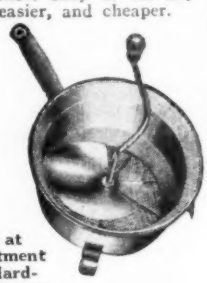

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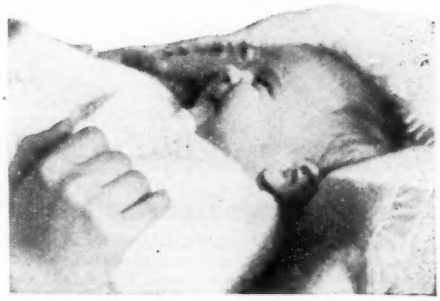

POSITIONS AVAILABLE

PUBLIC HEALTH NURSING lists "Positions Open" each month. Up to 50 words this service is *free to member agencies,* with a charge of $2 for an additional 50 words or less. To other organizations the charge is $2 for the first 50 words or less, and $2 for an additional 50 words or less.

WANTED—Orthopedic nursing consultant to work with state and local groups. Desired preparation—approved course in public health nursing, orthopedics and pediatric nursing. Extensive community organization and public speaking experience required. Apply giving complete details of background and references to Lawrence J. Linck, Executive Director, National Society for Crippled Children and Adults, Inc., 11 S. LaSalle St., Chicago 3, Ill.

WANTED—Two Public Health Nurses. Straight School Nursing Program. Prefer someone under thirty-five for permanent position. Staff of eight nurses. Excellent working conditions, five day week, good vacation period. Car essential. Salary open, compensation for use of car. Write Director of Health, Tacoma Public Schools, Tacoma, Washington.

WANTED—Supervisor and Teaching Supervisor in Rochester Visiting Nurse Association. Qualifications include graduation from college and public health nursing course. Inquire Miss Cora Warrant, Executive Director, Visiting Nurse Association, 130 Spring Street, Rochester 8, N. Y.

WANTED—Director, generalized health program—bedside care; PHN Certificate; Degree. Affiliation with Hospital here. Salary $225.00 per month depending on experience and qualifications. Apply, Miss Marcella Hayes, Visiting Nurse Ass'n., 1128 S. Mulberry Street, Muncie, Indiana.

WANTED—Public Health Field Nurses—generalized service. Orthopedic Nursing Consultant; School Consultant—high schools; Assistant Supervising Nurse—child health. Appointments under Civil Service, 38-hour week. Retirement pensions and tenure for satisfactory service. Apply to: Bureau of Nursing, New York City Health Department, 125 Worth Street, New York City 13.

WANTED—A nurse for work on a District Nurse staff—generalized program—population 27,733. Apply to Abbie M. Gilbert, Executive Director, District Nurse Association, Inc., 51 Broad Street, Middletown, Connecticut.

WANTED—Nurses for Staff Positions in Generalized Public Health Nursing Program located in Suburban Area adjacent to Washington, D.C. Salary $2250 per year. Opportunity for attending Universities part time in Washington, D.C. Reply: Director Nursing Bureau, Arlington County Health Department, Virginia.

WANTED—PUBLIC HEALTH NURSING CONSULTANTS IN ORTHOPEDICS—Completion of an approved course of study in public health nursing; advanced preparation in orthopedics, plus general public health nursing and orthopedic nursing experience. Salary $3001.00 per year. Bureau of Nursing, New York City Health Department, 125 Worth Street, N. Y. C.

WANTED—Public Health Nurse to work as second nurse in small V. N. A. Position open now to August or September, 1947. Salary $1700.00. Car and bag supplied by V. N. A. Write to Mrs. Edward W. Burgess, President, PCNA, Barnes Lane, Plymouth, Massachusetts.

WANTED—Nurse-Physical Therapist, experienced. Carry duties of Working Supervisor in a generalized program. Salary about $2500. Write: Director, Visiting Nurse Association, Springfield (3) Mass.

WANTED—Clinical Instructor, Nursing Arts Instructor, for General Hospital. Salary, $180 and complete maintenance. Address Director, School of Nursing, East Liverpool City Hospital, East Liverpool, Ohio.

WANTED—Qualified Public Health Nurse for our five-nurse organization. Generalized nursing program includes School Nursing. Local opportunities for further education. Write giving qualifications to Miss Julia M. Williams, Director, The Visiting Nurse Association of Windham, Willimantic, Connecticut.

WANTED—Staff nurse, minimum qualifications one year post graduate public health nursing preparation including four months of supervised field work. Salary range, $1650-$2010 per year. Reply: Miss Anna C. Gring, Director, Bureau of Public Health Nursing, Montclair, New Jersey.

WANTED—Registered Nurses, College degree, Public Health Certificate. Five day week, travel position, $220 per month, full maintenance in field. Apply American National Red Cross Pacific Area, Nursing Service, Civic Auditorium, San Francisco, Calif.

WANTED—Qualified public health physicians and public health nurses in Texas. Applicants should have specialized training or experience in public health work. George W. Cox, M.D., State Health Officer, Austin, Texas.

WANTED—Public Health Nurse Supervisor and Public Health Staff Nurse in bi-county health department servicing 41,000 people; generalized program; salary range for supervising nurse $210-$260, plus travel; for staff nurse $175-$220, plus travel; apply Alexander-Pulaski County Health Department, Board of Trade Building, Cairo, Illinois.

WANTED—Nurses for public health work in Florida, urban and rural areas. Write Merit System Supervisor, Florida State Board of Health and Crippled Children's Commission, Professional Building, Gainesville, Florida, for full information and application blank.

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WANTED—Assistant supervisor in generalized program including tuberculosis. College degree, experience required. Salary open. One Staff nurse, experience and home theory. Eligibility New Jersey registration essential. Apply Atlantic Visiting Nurse and Tuberculosis Association, 2332 Pacific Avenue, Atlantic City, New Jersey.

WANTED—Well qualified Public Health Nurse with degree to assume responsibility for the Tuberculosis Program. Must have academic work in Public Health Nursing. Generalized experience and administrative experience. Specialized Tuberculosis service desirable but not essential. For particulars write to Mrs. Elizabeth Earle, Director, Bureau of Nursing, Arlington, Virginia.

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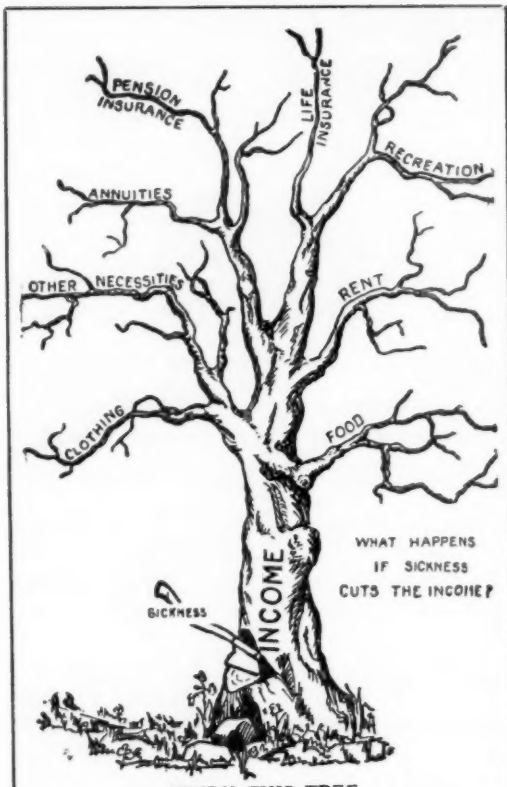

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